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HEALTH CARE REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

VOLUME XIII

**Issues Relating to Inner-City and Rural
Communities**

FEBRUARY 7, 1994

**H.R. 1200, American Health Security Act of 1993;
H.R. 2610, MediPlan Act of 1993; and Other Single-Payer Options**

FEBRUARY 9, 1994

**Alternative Health Reform Proposals Including
H.R. 3080, H.R. 3704, H.R. 3652, H.R. 3222, and
H.R. 3698**

FEBRUARY 10, 1994

Serial 103-92

Printed for the use of the Committee on Ways and Means



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ISSUES RELATING TO INNER-CITY AND RURAL COMMUNITIES

MONDAY, FEBRUARY 7, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 1:30 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 21, 1994

PRESS RELEASE #25
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
ISSUES RELATING TO INNER-CITY AND RURAL COMMUNITIES

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to health care service delivery in inner-city and rural communities, as discussed in the President's health care reform proposals. This hearing will be held on Monday, February 7, 1994, beginning at 1:30 p.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "As we move to enact universal health care coverage, we need to take steps to ensure that residents of inner-city and rural areas have access to the health care they need. Lack of insurance is only one part of the problem in these communities, which for too long have suffered from a shortage of physicians and health care facilities."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Administration estimates that 72 million Americans live in inner-city and rural areas where there are insufficient numbers of providers or inadequate facilities to provide health care services.

While access to health insurance is a problem for many residents of inner-city and rural communities, ensuring the infrastructure needed to deliver services will require more than a guarantee of universal coverage. Health care reform proposals that rely on competing health plans to provide access to services need to be adapted for communities which currently suffer a shortage of providers. Assuring that health plans provide accessible health services to inner-city and rural residents is essential to the success of the Administration's strategy.

The Administration's health care reform legislation includes provisions intended to address the concerns of underserved communities. These provisions include those designed to assist "essential community providers" and those designed to provide support for the creation of health networks in underserved areas. However, the Administration proposal also would substantially reduce Medicare's disproportionate share adjustment and indirect medical education adjustment which currently provide assistance to inner-city hospitals serving the indigent. Witnesses are asked to comment on the implications for inner-city and rural communities of the Administration's health reform proposal in general and these proposals in particular.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

* * * * *

Chairman STARK. Good afternoon.

The subcommittee will continue hearings on health reform with a discussion of issues affecting inner-city and rural communities.

Because they include a disproportionate share of the uninsured, guaranteeing universal coverage is a critical step in insuring access to health services for residents of inner-city and rural communities. Twenty-five percent of the residents under age 65 here in the District of Columbia, for example, are uninsured. Agricultural workers in our rural communities are uninsured at substantially higher rates than other Americans.

Insurance coverage is not enough, however, to address the unique access problems faced in these areas. These communities lack the health care infrastructure, hospitals, physicians and other providers needed to deliver health care. For example, 28 States have at least one county without a physician.

The capital needs of safety net hospitals are chronically underfunded. Many of these facilities are struggling to continue to serve as the only provider for many costly, specialized services such as trauma care, neonatal, intensive care and emergency psychiatric treatment.

Last year, H.R. 2294, the Essential Health Facilities Investment Act, which the Chair introduced, offered to expand the essential access community hospital program for rural health networks to all 50 States, and established a similar program of assistance for networks of urban essential community providers to provide Federal loans and grants for meeting the capital needs of safety net providers.

The shortage of providers and lack of infrastructure is aggravated by the greater need for services in both these communities. Violence, drug abuse and homelessness plague our inner cities and put immense stress on the health care system. Residents of rural areas are older, sicker, poorer, and have higher rates of unemployment and chronic illness than other Americans.

The subcommittee has been concerned about the problems of inner-city and rural areas. As the committee of jurisdiction over the Medicare program, we have worked to protect access for Medicare beneficiaries in these communities through the disproportionate share adjustment, the Equal Access Community Hospital program, and other targeted assistance.

As recently as last June, the subcommittee held a hearing to discuss approaches we might consider to address needs of inner-city and rural areas as we undertake health care reform legislation.

Since then, we have received the administration's Health Security Act which includes provisions intended to target assistance to the special needs of rural and inner-city communities. These include authorizations for a number of public health service initiatives for underserved populations, capital funding for community health plans and practice networks, and authorization for a new program of financial assistance for capital development of community health plans and practice networks.

Our witnesses today have been asked to discuss the overall impact of the administration's proposal on rural and inner-city areas. We welcome their assistance.

Mr. Thomas.

Mr. THOMAS OF CALIFORNIA. Thank you, Mr. Chairman.

As we have seen with the testimony, the inner-city and rural communities have far more in common than a lot of people realize in terms of trying to get their health care needs met. We are dealing with somewhat unique problems, but I think you will find that the testimony from our colleagues, both from the rural and inner city, will show there is a lot more in common than most people realize.

There are unique instances; for example, the gentleman from Wyoming, my namesake, has an enormous population that comes into their States on periodic months visiting national parks. I have the Sierra Nevadas behind me that is the playground for millions from Los Angeles County, and when they fall down and break their leg, it is my hospitals that they get airlifted to.

There are unique situations, but by and large what you are going to find is that as we debate the question of insuring all Americans, my colleagues are here to help us understand better who and where the phrase, "all Americans" encompass.

I look forward to their testimony.

Chairman STARK. Mr. McCrery.

Our first panel is comprised of the distinguished cochairs of the Rural Health Care Coalition joined by one of their principal members: Hon. Craig Thomas from Wyoming, is backstopping Hon. Charles Stenholm of Texas and Hon. Pat Roberts of Kansas. Thank you for coming. We are glad you would take the time to be with us.

If you have presented written statements, they will appear, without objection, in the record in their entirety. In any event, we welcome your addressing us. Are you the leadoff, Charlie? Please do.

STATEMENT OF HON. CHARLES W. STENHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, AND COCHAIRMAN, HOUSE RURAL HEALTH CARE COALITION

Mr. STENHOLM. We appreciate very much the opportunity to testify before your committee today. We appreciate your remarks and I want to associate myself particularly with Mr. Thomas' remarks that there is a lot more in common between inner city and rural than might meet the common eye.

As you know, Pat Roberts and I cochair the Rural Health Care Coalition in the House of Representatives and have been working with this coalition over the past several years to see that the potential health system reforms do in fact affect rural areas in a very fair and efficient way.

Today I would concentrate my remarks in three areas: First, in the area of work force; Second, in the area of integrated delivery systems; and finally, the small business aspects since rural America has many, many small businesses.

As I am sure you understand, the shortage of health care professionals in rural areas has historically been and continues to be the central barrier to access to health care services in many rural communities. There are approximately 2,000 health professional shortage areas in the United States and over half of those are in rural areas.

In the State of Texas, approximately one-half of the 254 counties are designated shortage areas. Of those, 88 percent are rural. As you know, the measure of physician-to-population ratio is commonly used as an indicator of underserved populations. In rural Texas, there are 71.1 physicians per 100,000 people. In urban parts of the State, the physician-to-population ratio is more than double the rural figure. In the Nation as a whole, the average is 248 physicians per 100,000 people. The figures for nurses and other providers in Texas add to the picture of underservice in our rural areas.

Rural counties in general rely on nurses with less training than the nurses who practice in urban areas. The majority of nurses practicing in rural Texas are licensed vocational nurses. While we are enormously grateful for their services, rural communities are in need of nurses with more advanced training.

If attempts to improve access to quality care in rural areas through organizing and building rural health care delivery systems are going to be successful, we first need an adequate supply of health care providers practicing in rural areas.

The President's bill contains a number of tax incentives to encourage primary care providers to locate in rural areas. These types of incentives are supported by many rural health advocates. However, it is important to note that financial incentives alone are not likely to be sufficient to significantly increase the number of providers locating in rural areas.

I personally am very interested in some of the new and innovative things that are being tried in my State and elsewhere in which in rural communities that we in fact need to do something to help ourselves. An example is the areas where they are starting locally funded scholarship programs, such as the community scholars program in Texas. I think community-based incentives to attract men and women to doctoring and nursing, matched with State funds and also perhaps, Federal matching funds, makes a lot of sense.

Moving on to the integrated delivery systems, in looking at tax incentives for rural and underserved areas, I also encourage the committee to place a priority on incentives to build these integrated health care delivery and communication systems. This is something again where it is going to require a tremendous amount of cooperation between local, State and Federal efforts if we are in fact going to meet the needs of rural areas.

Finally, I would point out, in the area of small business, a major area of concern for the coalition is the effect of systemwide reforms on small businesses which make up a significant percentage of the employers in rural America. We encourage the committee to carefully explore the issue of employer mandates before making a decision which would negatively impact job growth and availability in the already fragile rural economy.

While the coalition has not officially taken a position in support or opposition to the issue of employer mandates, there are many of us who have grave reservations about these mandates and we are united in our concern about how mandates could impact upon small business employment in our rural communities.

[The prepared statement follows:]

Testimony of
CONGRESSMAN CHARLES W. STENHOLM
CO-CHAIRMAN OF THE HOUSE RURAL HEALTH CARE COALITION
before the
Committee on Ways and Means, Subcommittee on Health
February 7, 1994

Mr. Chairman, I appreciate this opportunity to testify before your Committee regarding the impact of health system reform on rural America. As you know, I, along with Representative Pat Roberts of Kansas, co-chair the Rural Health Care Coalition in the House of Representatives. The Coalition has been working on determining the effects of potential health reforms on rural areas for the past year and we are pleased to be able to share some of our findings and concerns with you today.

WORKFORCE

As I am sure you understand, the shortage of health care professionals in rural areas has historically been and continues to be the central barrier to the access of health care services in many rural communities. There are approximately 2,000 health professional shortage areas in the United States and over half of those are rural areas. In the state of Texas, approximately one half of the 254 counties are designated shortage areas; of those, 88% are rural. As you know, the measure of physician to population ratio is commonly used as an indicator of underserved populations. In rural Texas, there are 71.1 physicians per 100,00 people. In urban parts of the state the physician to population ration is more than double the rural figure. In the nation as a whole, the average is 248 physicians per 100,000 people. The figures for nurses and other providers in Texas add to the picture of underservice in our rural counties. Rural counties, in general, rely on nurses with less training than the nurses who practice in urban areas. The majority of nurses practicing in rural Texas are Licensed Vocational Nurses (LVNs). While we are enormously grateful for the services of our LVNs, rural communities are in great need of nurses with more advanced training.

If attempts to improve access to quality health care in rural areas through organizing and building rural health delivery systems are going to be successful, we first need an adequate supply of health care providers practicing in rural areas. The Coalition places a priority on assuring that any health reform plan that is passed contains effective measures to encourage providers, especially primary care physicians, nurse practitioners, physician assistants and certified nurse midwives, to practice in underserved areas.

H.R. 3600 contains a number of tax incentives aimed at encouraging primary care providers to locate in rural areas. These types of incentives are supported by many rural health advocates though it is important to note that financial incentives alone are not likely to be sufficient to significantly increase the number of providers locating in rural areas. Some rural states and facilities, particularly health centers and rural health clinics currently are using innovative training programs to encourage providers to practice in rural areas. I hope that workforce provisions included in health reform will encourage and provide incentives for these community facilities to continue to be involved through direct funding for their educational efforts.

I trust that the Committee will work to direct the dollars spent on health reform and provider incentives in such a manner as to achieve the most effective results possible. There are several questions I would encourage the Members of the Committee to investigate further: Can the funds and tax incentives available to providers reasonably be expected to alleviate provider shortages in underserved areas? Will the new structure of Graduate Medical Education financing and other medical education reforms significantly improve the number of primary care providers practicing in rural America? Do provisions in the bill, including licensing requirements, adequately and appropriately expand the utilization of mid-level practitioners?

INTEGRATED DELIVERY SYSTEMS

In looking at tax incentives for rural and underserved areas I also encourage the Committee to place a priority on incentives to build integrated health care delivery and communications systems. These measures can help to alleviate some of the non-financial concerns of isolated rural practitioners such as the heavy workload and the

absence of professional consultation and support services.

Community-based initiatives to coordinate services and build network systems are a necessary component of improving access to quality care in rural areas. I encourage the Committee to consider options to help communities in the planning and implementation of delivery networks including technical and financial assistance for: information and telecommunications systems; enabling services such as transportation and translation; the recruitment and retention of providers; and assistance in meeting capital and solvency requirements for health plans.

SMALL BUSINESS

Another concern of the Coalition is the effect of system-wide reforms on small businesses, which make up a significant percentage of the employers in rural America. We encourage the Committee to carefully explore the issue of employer mandates before making a decision which could negatively impact job growth and availability in the already fragile rural economy. While the Coalition has not officially taken a position in support or opposition to the issue of employer mandates, there are many of us who have grave reservations about these mandates and we are united in our concern about how mandates could impact small business employment in our rural communities.

Thank you for this opportunity to testify on these matters of great importance to me and a number of our colleagues. I am pleased to turn over the floor to my Co-Chair, Representative Pat Roberts, who will discuss several other concerns of the Coalition.

Chairman STARK. Mr. Roberts.

STATEMENT OF HON. PAT ROBERTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS, AND COCHAIRMAN, HOUSE RURAL HEALTH CARE COALITION

Mr. ROBERTS. Thank you, Mr. Chairman.

Usually the Stenholm-Roberts posse rides in the sometimes powerful House Agriculture Committee and we are usually on time. However, I note with the green, amber and red light, I may go over about 1 or 2 minutes and I beg the subcommittee's indulgence.

Chairman STARK. That is just habit. We tend to, as a matter of comity, ignore it.

Mr. THOMAS OF CALIFORNIA. I would urge the gentleman from Kansas not to abide directly by the light, but to use it as a guide.

Mr. ROBERTS. Sort of a guiding light, Bill.

Thank you for the opportunity to discuss the aspects of the rural health care problem. As of today, we have 151 members who are privileged to serve in a rural area and we got a little tired of banging our knuckles raw on the door of HCFA or HHS or any one of the alphabet soup acronyms, so we joined together and have 151 of us, and it is bipartisan.

I would like to address some of the concerns that I have with President Clinton's health care reform plan and its impact on infrastructure development, on governance and control of health care. We sent a letter, Mr. Stenholm and Mr. Slattery, who is also a member of the Coalition and Mr. Gunderson and myself to the American Hospital Association, the American Nurses Association, the AMA, American Association of Medical Colleges, the National Rural Health Association, the American Academy of Family Physicians, the National Association of Community Health Centers, the Rural Policy Research Institute, the National Alliance of Nurse Practitioners, and the National Rural Health Network, and we are getting a lot of letters back.

We asked about the President's plan with regard to work force, infrastructure, reimbursement issues and governance, information systems, and small business. These are the concerns that we are hearing back from these groups.

I think everybody knows the Nation's rural hospitals are experiencing financial shortfalls and shoestring budgets. In general, rural hospitals serve a higher population with regard to Medicare and a lower level of insured patients. So this provides less opportunity for our hospitals to subsidize losses on both the Medicare and the Medicaid patients from any private pay patient.

In Kansas as in Texas, we have 60 Medicare-dependent hospitals, and Medicare reimburses rural hospitals about 90 cents on the dollar. I am deeply concerned about the proposal to cut an additional \$124 billion from the Medicare budget in order to pay for alleged health reform. Unless additional funding sources are included, these cuts will really cripple the small rural hospital; many could close their doors.

Most of the hospitals with 50 beds or less are in my 66-county district, so it would be a real problem. The Health Security Act does take several steps to invest in expansion of primary care services in underserved areas, and I support such efforts.

However, under the President's plan, a large portion of these funds would be administered under something called the qualified community health plans and practice networks program which would give the greatest preference to facilities such as health maintenance organizations that are generally utilized in large urban areas.

Publicly funded providers who band together are given a lower preference for receiving support, and that is not good news. There are similar concerns in the funding of educational and prevention programs.

I support the plan's real initiative to educate our youth in healthy activities, but in establishing the criteria for local education agencies to receive the planning grants for educational programs, the President's plan limits such grants to agencies that enroll a minimum of 25,000 students. No school district in 85 rural counties in Kansas would qualify for such a grant.

State and local governments must have the flexibility to structure the health care delivery system and take into account these special circumstances. Under the President's plan, regional health alliances function under control of the National Health Board. This board is responsible for determining a global budget as well as setting caps on insurance premium spending for each regional alliance.

I am concerned that these regional alliance premium caps will be developed on what we call historical data. Since payments to rural providers are lower than those to our urban counterparts, this will lock in lower payments to the rural provider.

Mr. Stenholm, myself and Mr. Thomas and all of us on the Health Care Coalition have been working to get those Medicare reimbursements at least back up to cost. If we base payments on historical data, again we are going to have a lot of problems.

Another concern for rural areas is the global budget concept. This is basically in my opinion a zero-sum game. If one alliance spends more, then another will have to spend less. Rural alliances made up of farmers and ranchers who are engaged in hazardous occupations could be forced to exceed their budget.

If the regional health alliance runs out of money, individuals and employers in the region must make up the shortfall. That is taxes up and down Main Street. But if the amount of money that can be spent in the region is capped, how else can the shortfall be made up without some form of rationing. Due to a lack of services and providers, our rural citizens are already experiencing rationed health care.

The Federal Government holds broad regulatory powers by being the sole designator of underserved areas that link our local communities to important Federal funding. This could be remedied, and I would make a suggestion to the subcommittee, Mr. Chairman, by utilizing the Health Professional Shortage Area, or what we call a HPSA, instead of the medically underserved population.

HPSA designations allow for more State control to target the areas for Federal funding. In addition, the Clinton plan in my opinion fails to adequately address the important issue of the rural health delivery systems that cross State lines.

In western Kansas and in my neighbor's county, we have facilities in Cheyenne County, Kans. and Dundee County, Nebr. Many rely on facilities in Denver, Colo. So rural residents should not be forced to travel any greater distances to seek care in their own States when a closer facility simply could be utilized in a neighboring State.

I have some information with regard to the electronic information system. We are going to need additional grants to get up and running because rural hospitals fall short in terms of funding.

Mr. Chairman, I am simply going to say I look forward to working with this committee to develop workable health care reform. There are many similarities, I think, between the Health Security Act and some alternative health reform bills, that is, the President's plan, in the Congress.

I think most of us on the Coalition would agree that we must reform the insurance market. We must implement administrative simplification measures. We must increase the deductibility to the self-employed. We must reform the malpractice laws and remove what we call the antitrust barriers.

Medical savings accounts have also been proposed as an alternative method to control the skyrocketing costs. I just make the observation if we did all that, it would be a landmark policy change. The idea that somehow these recommendations represent only incremental reform and not substantive reform is, I think, false.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY BY THE HONORABLE PAT ROBERTS (R-KS)
HEARING BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FEBRUARY 7, 1994
1:30 P.M.
1100 LONGWORTH BUILDING

Mr. Chairman, thank you for the opportunity to discuss rural health care with you today.

I serve as co-chairman of the House Rural Health Care Coalition, a group of 151 Members concerned about health care in rural areas. Rural Americans face unique health delivery problems that stem from a shortage of health providers, services and facilities, as well as geographic barriers. Today, I would like to specifically address concerns with President Clinton's health care reform plan and its impact on infrastructure development, governance and control of rural health care.

Infrastructure

Our nation's rural hospitals are experiencing financial shortfalls and shoestring budgets. In general, rural hospitals provide health care services to a higher Medicare population and a lower level of insured patients. This provides less opportunity for our hospitals to subsidize losses on Medicare and Medicaid patients from private pay patients. In Kansas, we have 60 Medicare Dependent Hospitals. Medicare reimburses rural hospitals about 90 cents on the dollar. I am deeply concerned about the proposal to cut an additional \$124 billion out of the Medicare budget in order to pay for health care reform. Unless additional funding sources are included, these cuts will cripple small rural hospitals. Many will close their doors.

The Health Security Act takes several steps to invest in the expansion of primary care services in underserved areas and I support such efforts. However, under President Clinton's plan, a large portion of these funds would be administered under the Qualified Community Health Plans and Practice Networks Program, which would give greatest preference to facilities such as Health Maintenance Organizations, that are generally utilized in large, urban areas. Publicly-funded providers who band together are given a lower preference for receiving support.

There are similar concerns in the funding of educational and prevention programs. I support the plan's initiative to educate our youth in healthy activities. But in establishing criteria for local education agencies to receive planning grants for educational programs, the Health Security Act limits such grants to agencies that enroll a minimum of 25,000 students. No school district in any of the 85 rural counties in Kansas would qualify for a grant.

Each rural community has its unique set of service delivery problems, resources, and priorities. State and local governments must have the flexibility to structure health delivery systems that take into account these special circumstances.

Under the President's plan, regional health alliances function under control of the National Health Board. This Board is responsible for determining a global budget, as well setting caps on insurance premium spending for each regional alliance. I am concerned that these regional alliance premium caps will be developed based on historical data. Since payments to rural providers are lower than those to their urban counterparts, this will lock in lower payments to rural providers.

Another concern for rural areas is the global budget concept. This is basically a zero-sum game. If one alliance spends more, another will have to spend less. Rural alliances, made up of farmers and ranchers who are engaged in hazardous occupations, could be forced to exceed budgets. If the regional health alliances run out of money, individuals and employers in the region must make up for the shortfall, most likely by increasing taxes up and down main street. But if the amount of money that can be spent in the region is capped, how else can the shortfall be made up without some form of rationing? Due to a lack of services and providers, rural Americans are already experiencing rationed health care.

The federal government holds broad regulatory powers by being the sole designator of underserved areas that link local communities to important federal funding and by retaining discretion for funding the development of networks. This could be remedied by utilizing the Health Professional Shortage Area, or HPSA, instead of the Medically Underserved Population. HPSA designations allow for more state control to correctly target areas for federal funding.

The Clinton plan fails to adequately address the important issue of rural health delivery systems that cross state lines. In western Kansas, residents have formed the State Line Health Network, which includes facilities in Cheyenne County, Kansas, and Dundy County, Nebraska. Denver, Colorado, has become a regional health center for rural residents of several surrounding states. Rural residents should not be forced to travel greater distances to seek care in their own states when closer facilities are already being utilized in neighboring states.

Information Systems

Electronic information systems are important to rural health and I support the administrative's initiative to move toward electronic billing and standardized forms. However, these information systems are expensive and small rural hospitals may struggle to come up with the financing needed. The implementation process must be phased in so that rural communities will have adequate time to build funds.

Telemedicine is particularly important to rural health delivery systems. It assures less professional isolation for rural physicians, a critical component needed to recruit more health providers to rural areas. However, without the assurance of payment for telemedicine services, the full potential of telemedical technology will never be realized. Currently, HCFA provides reimbursement for certain radiology and pathology services, but does not recognize medical consultations performed via telecommunications links. This administrative roadblock prevents the development and expansion of these systems in rural America. The Rural Health Care Coalition has met with HCFA officials about this but is awaiting a response.

Mr. Chairman, I look forward to working with this committee to develop workable health care reform. There are many similarities between the Health Security Act and alternative health reform bills in Congress. Everyone agrees that we must reform the insurance market, implement administrative simplification measures, increase deductibility to the self-employed, reform malpractice laws, and remove anti-trust barriers. Medical savings accounts have been proposed as an alternative method to control skyrocketing costs. I support measures to implement these reforms.

Mr. Chairman, thank you for this opportunity. I urge the Committee to take a serious look at our recommendations and consider the impact any comprehensive health care reform initiative will have on rural and underserved areas.

Chairman STARK. Craig.

STATEMENT OF HON. CRAIG THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING AND CHAIRMAN, TASK FORCE ON HOSPITALS AND CLINICS, HOUSE RURAL HEALTH CARE COALITION

Mr. THOMAS OF WYOMING. Thank you very much, Mr. Chairman. I appreciate the opportunity of visiting with you a bit about rural health care.

There are several points I would like to make during the brief comments. One is that a "one fits all" program doesn't work in this country. We have great diversity.

Another is that the available facilities in rural areas are quite different than they are where there is a larger population, and I think we have to deal with that.

Another is the need for antitrust reform and redefining hospitals so that we can reimburse them on a different basis. I am sure we agree that rural people need to be on an equal footing when we talk about reforming health care.

A nationalized system simply won't fit the whole country, whether it be managed competition, or nationalized alliances, both of which are in the President's plan. These proposals don't fit the diversity that we have. The notion of putting together a large group of buyers with leverage to select among buyers is not a new idea; agriculture has been doing it for years, but it doesn't work well in a place like Wyoming.

We have 460,000 people, nearly 100,000 square miles. The New England Journal of Medicine said that it takes approximately 180,000 people to put together a managed care unit. The largest town is something less than 60,000 in Wyoming. So it makes it quite a different situation.

We talk about goals, but all of us generally agree we need to increase access, do something about decreasing costs and maintaining quality, but access in a rural area means something quite different.

In urban areas generally if you have the financial support, you have access. In Wyoming, you may not have access despite having the financial backing to do that. We need to work with nurse practitioners and physician's assistants. In Sublette County, Wyo., the largest town is Pinedale, of about 3,000. There is one physician in the county. It is 100 miles to the closest hospital, and Dr. Johnson works well there.

Your daughter knows a lot about this kind of thing, Mr. Chairman. All rural areas are not the same. I noticed with some interest in Arkansas they had 89 hospitals generally serving an area of 580 square miles. Wyoming has 25 hospital serving an average area of about 3,700 square miles, so it is quite a different matter.

The administration refers in their bill to rural areas being served by things such as migrant and community health centers, rural health clinics, federally qualified health centers, family planning clinics, school-based clinics, and calls them essential community providers. We have such facilities in my State, two migrant centers, some 400 miles apart. So this sort of an approach will not deal with our problems.

My friend has already mentioned the reduction in Medicare. Our South Big Horn Hospital, devoted 80 percent of their patient care to Medicare patients. So not being reimbursed or being underreimbursed for Medicare is an element of great concern.

I too think that there are some fundamental changes that could be made without trying to replace the whole system; if we could do something about fundamental insurance reform so that people aren't denied coverage, and if we could do something about anti-trust reform. We finally put together two hospitals in Cheyenne last year and it will be a more effective approach. Telemedical services are also something that is very meaningful to us.

I suppose we have a unique situation, but I think if we are not careful all the tertiary care in Wyoming will go to the border areas: Salt Lake City; Billings, Mont.; Rapid City, S. Dak.; Denver, Colo.; and we will be left with nothing, but very basic care.

So to a State where there is as many miles, I think that would be a bad situation.

My main plea is that we follow H.R. 3078, which we put in the Rural Health Care Coalition, which redefines hospitals. South Big Horn ended up with a 4 percent occupancy, over 80 percent Medicare. They couldn't function with the regulations. If we could redefine those, and we have done that in Montana with a special appropriation, if we could do nothing more than keep a 24-hour emergency room, these folks need a facility.

They can't support a full-service hospital facility—if we could redefine that so there could be Medicare/Medicaid, the payments made to something less than what we define as a full-service hospital, we think that would be particularly useful.

That provision exists in the Chafee bill and the Cooper proposal as well as Mr. Michel's proposal. It does not exist nor does it fit apparently in the administration bill.

Mr. Chairman, we appreciate your interest in the uniqueness of rural areas and hope to work with you as we to something that will be workable for all of us.

Thank you.

Chairman STARK. We thank all of you.

[The prepared statement follows:]

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TESTIMONY BY THE HONORABLE CRAIG THOMAS (AL-WY)

HEARING BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

**HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES**

**FEBRUARY 7, 1994
1:30 P.M.
1100 LONGWORTH BUILDING**

Mr. Chairman, thank you for the opportunity to testify before your subcommittee. I appreciate you holding this hearing as Congress moves forward on health care reform. One thing is certain, no matter what plan is adopted, rural people must be on equal footing as those who live in urban areas.

Some policy experts advocate a nationalized system of health care as the solution, while others advocate a "managed competition" approach. In the administration's case, it recommends both. However, without real state flexibility neither system is adaptable to the circumstances confronted daily by rural people.

A study published in the New England Journal of Medicine found that areas need at least 180,000 people to support the most basic managed care program. The largest town in Wyoming is less than 60,000. We do not have one urban area. So when you are talking about health care reform, you need to include workable answers for people in a state of 435,000 rural residents.

My state faces a severe health professional shortage. We also encounter difficult weather conditions that can change without a moment's notice, geographic boundaries that add an extra 100 miles to the drive for the nearest hospital and virtually no public transportation. These are the types of access problems common of rural areas -- often a greater hindrance to quality care than cost itself.

President Clinton's "Health Security Act" imposes a one-size, fits-all program. It relies heavily on managed care and government controls. But as you can see from the description of my communities, we do not fit in the administration's plan.

As the Chairman for the Rural Health Care Coalition Task Force on Hospitals and Clinics, I am deeply concerned about the president's complex health alliance structure. These alliances would be required to pool consumers, bargain with providers and collect

premiums. However, they disregard the most important component rural areas need -- flexibility. It is difficult to bargain with providers in a rural areas when there are not any.

Not all rural areas are alike. Wyoming has 25 sole community hospitals that on average service approximately 3,700 square miles. By contrast, Arkansas has approximately 89 hospitals servicing an average of 580 square miles. While Arkansas is also considered rural, Wyoming is twice the size, with one fifth of the population. What might work for Arkansas people will not work for Wyoming people.

The administration claims states like Wyoming will not have a problem with its health alliance structure because the number of providers, allowed to participate, would be expanded. For instance, the alliances would automatically approve migrant and community health centers, rural health clinics, federally-qualified health centers, family planning clinics and school-based clinics as "essential-community providers." All other providers, wishing to participate, would have to apply to the Secretary.

Despite the expanded provider provision, rural areas will still be affected. The "essential community provider" definition does not include the most common facilities in rural areas -- sole community hospitals (SCHs) or Medicare Dependent hospitals. Out of all the categories listed for expansion, Wyoming has two migrant health centers in Worland and Guernsey, which are eight hours apart. What happens to the folks in between? Or the residents located in the rest of the Northeastern and Southwestern parts of the state? Where will they go to receive care? How are these alliances an answer?

The president's plan will also make it difficult for rural areas by slashing \$124 billion from Medicare reimbursement. After all the time and energy the Rural Health Care Coalition has spent in improving the level of reimbursement to rural areas, this cut puts us back to square one. The administration claims all the "new-paying patients" with insurance policies will offset the cut. But the fact is, so-called charity care is not a major problem in rural areas. Medicare and Medicaid reimbursement is the bulk of our facilities. For example, during 1993 one hospital in Wyoming received \$6.9 million in Medicare reimbursement. It wrote off \$1 million for charity care. As you can see, Wyoming's facilities depend much more on federal reimbursement programs, and any additional cuts will force our providers to shut their doors. And who would lose? Wyoming's rural residents.

Health care reform is suppose to improve the delivery of care to both urban and rural people. It is not suppose to risk the limited number of providers that rural areas so desperately depend on.

I suggest Congress focus on measures that can be enacted today. Changes like fundamental insurance reform, anti-trust reform, reimbursement for telemedicine services, tort reform, and improving health professional recruitment programs. These are the steps that will improve the rural health care delivery system. States like mine need flexibility to

reform their health care delivery system, yet the president's plan only provides two choices -- health alliances or single-payer plans. Frankly, neither will work in Wyoming.

If the administration's plan, or any other health care reform measure, wants to foster integration among facilities and providers, the plan must include flexible measures. I have one specific suggestion, my bill, H.R. 3078, the "Rural Emergency Access Care Hospital Act." It complements any comprehensive health care reform plan. Many rural communities resist closing an underutilized facility, for fear of losing the emergency room. My bill, however, helps reduce excess capacity. It also helps create a network of satellite clinics and full-service hospitals in rural areas.

Currently, if a facility has a difficult time staying open due to high regulatory costs and low in-patient stays, it is prohibited from downsizing to an emergency medical center. Medicare will not recognize a facility that does not meet all the conditions of participation. As a result, a facility wishing to downsize will lose its Medicare Part A reimbursement. My bill makes this regulation more flexible by creating a new limited service category. Small rural hospitals could convert to "Rural Emergency Access Care Hospitals" (REACH), provided they meet the following qualifications: 1) obtain approval from the Secretary certifying that access to critical services would be severely limited to residents in the community if the rural hospital were to close; 2) be able to transfer patients to a nearby full-service hospital; 3) keep a practitioner, who is certified in advanced cardiac life support by the State, on-site 24-hours a day; and 4) have a physician on-call on a 24-hour basis. Hospital administrators view this as a solid solution to improve the rural health care delivery system.

H.R. 3078 has been folded into Sen. John Chafee's "Health Equity and Access Reform Today Act," Rep. Jim Cooper's, "Managed Competition Act," and Rep. Bob Michel's, "Affordable Health Care Now Act." I suggest it also be included in President Clinton's, "Health Security Act." As well as other measures to add real flexibility for rural health care reform. But there are many more needed. I have a list of those as additions to my testimony I will submit for the record.

Mr. Chairman, I hope solutions like the REACH bill and changes to the administration's "essential-community provider" definition, will be given serious consideration by the subcommittee. I also hope it focuses on reforms that can be put in place today.

Congress cannot afford to implement a national health care program that discriminates against rural people. Rural folks deserve access to quality health care just as much as those living in inner cities. And any comprehensive reform plan must take that into account.

Again, thank you for holding this hearing. I appreciate your interest in rural areas and look forward to exchanging other recommendations to improve our nation's health care delivery system.

Chairman STARK. Charlie, just to pick up on your question about the similarities. You mentioned 71 physicians per 100,000 and interestingly enough, here in the Anacostia region of the District of Columbia, we have about 200,000 people and we only have 117 primary care physicians.

Now I know about the trip from Laramie to Cheyenne which is one trip in the summer and another in the winter, but if you think about getting on a Metro bus from way out Pennsylvania Avenue to Georgetown, a couple of transfers with a couple of kids, there is indeed the question of providing access to populations who for one reason or another have their services limited.

I know that we have worked on this with the Coalition, Charlie, that you and Congressman Roberts cochair, trying to work out a way that we can expand access and provide the quality of care. In other words, it is an article of faith that you can operate a 10-bed hospital and support an MRI.

The question is how do you get folks in that area to a tertiary center or even a bigger hospital? Those are all problems, and they are not necessarily just related to any one solution to the uninsured.

I gather, Craig, that you are saying that we don't need any one of these particular plans, but you have 14 percent in Wyoming of your under-65 population uninsured.

Mr. THOMAS OF WYOMING. Yes.

Chairman STARK. Somehow or other it seems to me if we don't insure them, everybody else in Wyoming is going to be picking up the costs of their care, and that is a problem we are going to have to deal within addition to seeing that the resources are there once they get insurance.

Mr. THOMAS OF WYOMING. I agree with that, Mr. Chairman, but I think my point is we have to do it in a way that will work. The legislature put together some movement on small group insurance. We think we can make a fundamental change where people are not denied or cancelled insurance.

I have to confess that in my bill, I require insurance. I do it with a voucher. I, too, would like to see everybody insured to stop cost-shifting. My main point is that something that fits in Baltimore probably won't fit in Basin, Wyo.

Chairman STARK. The gentleman is correct. There is an immediate member of the Stark family who keeps reminding me of the problem since she is a care provider in your State. I am kept well aware of the problems of providing health care.

Mr. Thomas.

Mr. THOMAS OF CALIFORNIA. Back to the point that you made because people say yes, but you can't carry the analogy between the urban and the rural too far. I think it is amazing how far you can carry it, not just in terms of distances; 10 blocks is sometimes equal to 100 miles in the rural areas, but type of facilities that are available and the fact the debates tend to stem on the question of coverage, and there are very strong and eloquent statements made about the fact that we just don't want access; we want coverage.

Frankly, there are a lot of areas of the United States that would settle for access because coverage would follow and the distances, both mental and physical, are such that they are denied it.

We have real problems. There are a number of bills that have the economic incentives in there. My bill is \$1,000 a month tax credit for providers who move to frontier and rural areas.

That is not the only problem. Craig mentioned the telemedical. Technology today, I think, will provide not only greater resources so that you don't need as much of a facility there than you would have 10 years ago to provide really cutting-edge quality, but we are finding more and more that one of the problems is that professionals who go out into inner-city and rural areas don't get the professional reinforcement, the kind of in-service training.

This can be done more and more with modern technology. So my big concern—it says California on my name tag, but I represent a rural area and there are a lot of rural areas within urban States—is that we are in some way going to get our needs met.

My concern is that as we set up—if it is an employer mandate—with employer mandate, you get what in terms of access and coverage in rural areas? It is very easy to set up a structure, not even a one-size-fits-all, but a belief that a basic structure will enable unique areas to resolve their own problems and that is not the case.

My biggest concern as we go forward is to make sure that in both the urban and the rural area, there is enough flexibility in the system, not just at the State level, but also at the local and Federal levels, to be able to come up with a package that works.

If you are going to give universal coverage, you would like to have it actually there and working. We fought HCFA in terms of the rural formulas. We don't want to fight whatever the new agency is in making sure that what is on paper can be actually be delivered to areas.

We will work with you. We will screen it through you, and are looking forward to your input from your folks who clearly want to solve the problem for all Americans and make sure they are included because it is easy to set up a system that looks good on paper, but doesn't deliver the kind of health care you guys are concerned about.

I appreciate your testimony.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman.

I want to tell you a story. Early on in the discussions that the single-payer people had with Mrs. Clinton, I said to her, Managed competition will work in urban areas, particularly in the suburbs, but it doesn't work in the inner-city or rural areas.

Thirty-five percent of the American people live either in rural areas or in the inner cities. I had just driven across the country from Seattle to Washington, D.C., and had been impressed again with how rural the West is. I said, "Take the State of Nebraska. You can have all the managed competition you want in the world in Lincoln and Omaha, but the other 500 miles of Nebraska is sand hills and cattle ranchers and Native Americans, and you are lucky if you have a doctor in every thousand square miles when you get around Valentine and some of those places and you are never going to find managed competition working."

She had a health care meeting in Omaha and told me about the discussion she had with the Republican Governor of Nebraska who

said managed competition may make sense in Omaha and Lincoln, but we are going to have single payer across the rest of the State.

What tends to happen, what will happen, what happened in our State of Washington, is rural people are always fighting to get covered because we always take care of the big cities, and that is the history of the west.

You, I think, will in the end be much better off with a single-payer system and I would remind you of the history of Canada, although I am not pushing Canada. The original province to start the whole business was Saskatchewan, which is about as rural a province as there is.

The farmers there decided that a single-payer system made sense. They put it together in their legislature back in 1946. So the idea of a single payer is that you collect the money and provide the same care to everybody, then it becomes a matter of deciding how to do it.

I think if we are going to avoid dividing ourselves into rural and inner-city people on the one hand and suburban people on the other. The strongest position for you is the single payer.

Chairman STARK. There is some good free advice.

Mr. McCrery.

Mr. MCCREY. Thank you, Mr. Chairman. I thank my colleagues for coming before the committee today to share your concerns about rural health care.

I represent north Louisiana and it is not just the metropolises of Shreveport and Monroe, but also a vast rural area. So I share your concerns about our rural health care system. I would say to my talented friend from Washington that if I am not mistaken, the Medicaid and the Medicare systems are single-payer systems and that is what has caused much of the problem in our rural areas today.

Is there dependence on those government-funded systems and inadequate reimbursement schedules that we have had for rural hospitals and providers? So I am not sure that is the total answer, but we will debate that later.

I hope that whatever this committee comes out with will pay special attention to our rural areas, our rural providers, because if we don't, I suspect that the folks in north Louisiana will have to find a way to Shreveport or Monroe to get health care.

I appreciate your coming before the committee today and look forward to working with you on this topic.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Let me say to my colleagues I want to thank you for being here today and for testifying before this committee. I may represent urban Atlanta here, but many of you may not know that I grew up in rural Alabama, about 50 miles from Montgomery outside of a little place called Troy. My father had been a sharecropper, a tenant farmer, and in 1944 when I was 4 years old, he saved \$300 and bought 110 acres of land.

That was a good investment. My mother still lives on this farm, and I know what it is to grow up in a community where there is not a health facility, where there is not a doctor. So I share some of your concerns.

Whatever system, whatever plan that we are able to devise, we must have one where no one, whether they be in rural or urban America, will be left out or left behind, and I am very mindful of your concerns.

Thank you, Mr. Chairman.

Mr. ROBERTS. Could I make one final point?

Chairman STARK. Please.

Mr. ROBERTS. I know you made the point that there are 14 percent that are uninsured in Wyoming. I think that is because of the snowdrifts there. In Kansas, a poll has been recently taken, and we have 9 percent uninsured and furthermore, they asked them why and 38 percent of those were satisfied that they were uninsured, didn't want insurance, apparently.

What happens to the 62 percent is the problem with regard to the cost-shifting that goes on and if we do get reimbursed by Medicare 90 cents on the dollar, every one of my county seats in the 66 counties that I represent, 57,000 square miles that I represent has had to pass a bond issue.

I asked the First Lady when she came out to Kansas City and then out to Garden City, America, for the various summit meetings about the HIPCs—that is when they were HIPCs, not alliances.

I said "Well, we have a lot of deer and antelope that play out in my country, but I am not too sure about HIPCs." Why couldn't we have a high plains HIPCs; several States.

As regard to the single-payer system, and this was in reference to what you said Jim, we do have a little situation from Saskatchewan where we are very happy for their single-payer system because we are getting a lot of primary care doctors leaving Canada and coming to Kansas to take part in a system they feel is a little better.

One doctor from Liberal, Kans. that took part in the Garden City hearing had just come from Canada. His partner was supposed to come, but his partner died of a heart attack, and he was waiting for a bypass operation.

I only mention that in that there are some downside effects with regard to the serious illnesses that we would like to see some service out there as well. I am not trying to pick any kind of a discussion here, but I did want to mention that.

By the way, Liberal, Kans. is not an oxymoron.

Mr. STENHOLM. Mr. Chairman, one observation. Right now we have a very exciting experiment going on in one of the communities in my district in which they are creating a health clinic in an underinsured, underserved area of a city. It is small by comparison with Washington, D.C., standards, but the theory still makes good sense.

We have to bring the care to where the people are. It can be done. It is being done now on an experimental basis in a little kind of a trade-off or side bar from what we all know is to be clinic and migrant health concepts. This is something that we hope within a short period of time is going to show positive results in one community in attempting to deal with the underserved.

Mr. THOMAS of WYOMING. We are doing some of the same things. In Douglas, Wyo., they have reduced the number of acute care beds. They have long-term care beds to take care of the over-

head. They have brought the physicians into the building so that they have gotten away from duplication of expensive equipment and are helping them some with their administrative costs. They bring specialists around from the larger towns.

So there is a lot being done now to devise this distribution system of health care on our own and we are pretty pleased with that.

Chairman STARK. Pat, you touched on this and I don't want to let you all go—you represent not only rural constituents, but quite often independent constituents, and you suggested, Pat, that maybe some of the folks in Kansas just don't want insurance. Texas has darn near 25 percent uninsured.

My question is can we, with the exception of perhaps the occasional religious community, can we really let people go without insurance if we are going to have a universal plan?

I suggest that that may mostly be youngsters in their early twenties who think they are healthy, but they don't wear their motorcycle helmet, and they could get just as sick or they can get diabetes, and then without insurance, they become a cost to the community and haven't paid their fair share for insurance.

If we could agree on a plan, whatever it is, could we also agree that everybody has to be in it? You don't let people say, "To hell with it. I am going my own way."

Mr. ROBERTS. In Dodge City, that is sort of our motto. Let me take a stab, if I might, with regard to the health care summit or conference we had with Senators Dole and Kassebaum and administration witnesses and myself. Craig was supposed to be there, but he had another meeting as well, a similar meeting.

In the first place, there is no one in a rural area that is not receiving care. You have a small community caring, if I can refer to it in that way, that means that they are getting care. With only 9 percent uninsured, that is one of the lowest in the country. If you say 38 percent prefer not to be insured, I am not too sure that you want to mandate that those folks simply join a plan they can't afford.

There is cost sharing, but it is more due not because of that, but because that hospital only gets 90 cents on the dollar and we can't even pay our professionals what we have to pay them to attract people to come there; so the criteria already used in the current programs is at the wrong end of the telescope. Then the community has to pass a bond issue.

There is a revolution going on in the rural health care delivery system. We are doing everything we can just to hang on. I guess I would answer your question by saying this: We heard a lot of administration witnesses at that summit meeting. We had about 650 farmers and ranchers—no, make that 450—I had a politician's count—and they were sitting pretty quiet as we were going through all the ramifications of the President's plan.

Finally, Roberts stood up and said "I am not sure that the American dream is that everybody be level with everybody else," that this is an actual mandate. You get into the ideological argument whether this is an entitlement, a right and a mandate.

You are right; in our country, we like people to do what grandmother said to do, drink less, stay out of the smart juice, smoke

less, exercise, get into preventive medicine and wellness—you have that individual responsibility. I got a standing ovation.

I am not sure it made too many happy that were testifying, but we got some notice of it. I know where you are headed, but I don't know how you devise a mandatory system that is not going to be more regulatory, more costly, more paperwork and more red tape.

Chairman STARK. I am not sure I do either. I am just suggesting that you raise a question.

Mr. ROBERTS. It is a good question.

Chairman STARK. If 25 percent of the people in Texas stayed out of the plan, we would be in trouble.

Mr. STENHOLM. I would comment, if we have to mandate it, it ought to be mandated on the individual's opinion and then you get into choices that come with individual choice.

The biggest fear is for us to create the system and then mandate it and have somebody else pay for it. That gets us in big trouble. If there is any one message coming through loud and clear to me and all members from local governments, unfunded mandates, we have had enough of it.

We in Congress decide what is good for everybody, telling the States or businesses "You have to provide this and meet these criteria that sound good and are good," but then the cost associated with it becomes another third-party pay syndrome and that is what has gotten us into trouble with Medicare and Medicaid right now.

That is the challenge we are going to have.

Chairman STARK. In these hallowed halls, we put a big slash between Medicare and Medicaid. That is some other building over there that has Medicaid, Charley. We try to keep those separate.

Mr. STENHOLM. Pardon me, Mr. Chairman.

Mr. McDERMOTT. Let me come back to an issue—when I was in the State legislature, the biggest budget was the road budget. We used to argue, we raise all the taxes and where do we put the roads, in the rural areas. Boys from the rural areas always argued that is the way it has to be, you have to bring the farm goods in and put them out through the port.

We never raised the issue, in fact they never raised the issue that it was an individual responsibility to put roads in front of your farm because if we had done that, they would still be on gravel out there and we would have them made out of enamel in the cities because we raised all the tax itself. But it is clear that in a society if you are going to deal with an issue like transportation, you have to put it in the pot and those people who need it get their share out of it when they need it.

It seems to me that in health care, we are increasingly moving in that direction. That is the problem I have with the individual responsibility. Not that it isn't a good idea, but it was impossible to do in roads and in sewers and a lot of other things, and when you come to the issue of providing that costly, very technical health care we have in this country, it is impossible for individuals to do it for themselves.

So we have to join together some way. That is why it is not taking away the individual's responsibility, but some people in the rural areas, if they have a bad crop year, they are not going to be able to buy that premium.

What are you going to say to them when they show up at the hospital? I am sorry, you don't have a card. You are out.

I am not going to do that. Maybe you would do that to your people——

Mr. THOMAS OF WYOMING. We don't do that now.

Mr. McDERMOTT. Of course you don't. That is why it seems to me that those who can pay can——

Mr. THOMAS OF WYOMING. It is a pretty big leap to go from taking care of those who have had an unfortunate thing to turning it into a public utility, and it seems to me that roads are one thing that governments have normally done. Health care——

Mr. McDERMOTT. It wasn't in the old days.

Mr. THOMAS OF WYOMING. Why don't we do it for groceries as well, or housing, or automobiles? They are very important. We ought to make sure that everybody has one.

I think that is a great leap of faith to go from highways to health care in terms of being a socialized program.

Mr. ROBERTS. Most of the road systems in my 66 counties are maintained by the county, and then State and then Federal as best we can, although I at least have 5 bills in to designate Federal highways throughout my district. That is not entirely true, but——

Mr. McDERMOTT. That is called cost-shifting.

Mr. ROBERTS. If you want to continue to pay about 10 cents out of your disposable income dollar for the food and fiber market basket of food in this country, we are doing something right with regard to agriculture and our contributions and the belabored farm program.

One example, and this goes back to HEW and Secretary Califano who was worried about quality and cost containment. We came up with something called utilization review back in the 1970s with my predecessor and Keith Sebelius, who was here prior to me. All of a sudden, HEW popped out of the woodwork and said, "You are not going to have any Medicare payment being honored unless a team of three doctors reviews admissions to the rural hospital every 24 hours."

We looked at that and we said "By golly, we are for it," and the hospitals said, "You can't be for that. We can't do that."

We said if they can find us the three doctors, we will get a lot of primary physicians. That was ludicrous and it took 6 months to 1 year to get rid of that. That is the kind of thing in terms of an unfunded mandate that Mr. Stenholm, Mr. Thomas and Mr. Roberts are worried about with the heavy hands of the Clinton plan—that is my words, pardon me, the Health Security Act.

Chairman STARK. I want to thank the panel. Whatever we end up doing, we have over the 8 years I guess that I have chaired this subcommittee had great good rapport with the rural caucus, in our little area of Medicare. Each year we have done a little bit better and a little bit more.

Whenever we get through this major undertaking that we are in now, I pledge to you we are going to get back to that system again, because I can't believe that whatever we do this year will be the final word for the next 10 years.

So I look forward to continuing to get the bipartisan input and support that we have had in the past for a lot of tough Medicare

cuts where we have been able to protect both the rural providers and beneficiaries. I appreciate the input that the caucus has given us and look forward to your continued assistance.

Mr. STENHOLM. We appreciate the past and future support, Mr. Chairman.

Chairman STARK. Thank you.

The next witness—we don't seem to get enough of each other, Dr. Philip Lee, Assistant Secretary for Health, Department of Health and Human Services back again for his weekly visit. We still have some of the pills left from the last time, Dr. Lee, but we will get your new prescription today and we look forward to hearing your comments on access to health care in inner cities and rural areas under the administration's health care reform.

STATEMENT OF PHILIP R. LEE, M.D., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. LEE. Mr. Chairman and members of the subcommittee, I welcome the chance to testify. I just want to review briefly what is in the statement submitted for the record and then be prepared to respond to your questions.

Without a doubt, the current crisis in health care is more severe in inner-city and rural areas than it is in other areas of the country. I think it epitomizes the problem of health insecurity, and that is the fundamental problem that the Health Security Act proposes to deal with.

In the testimony, I describe the health care problems in rural and inner-city areas, and I won't repeat those for members of this committee because you are very familiar with them.

The lack of insurance, the lack of available providers, and the other barriers to access have contributed to the poor health status of many residents in rural and inner-city areas. Those are not the only problems, but they contribute significantly.

Under the Health Security Act, under the basic elements in the reform, first and foremost, everyone is covered, there is a comprehensive benefit package, and clinical preventive services are provided without copayments and deductibles. The alliances provide consumers with purchasing power which many lack today.

Indigent populations will receive subsidies to cover part or all of the costs of their premiums, cost sharing and in some cases, wrap-around services.

Self-employed, including farm families throughout the Nation, will be able to deduct 100 percent of the cost of health insurance premiums instead of the current 25 percent. Small businesses will be eligible for premium discounts, further stretching their health care dollars. Providers will no longer receive lower payments when they care for low-income patients.

Medicare bonus payments for physicians practicing in underserved areas will be doubled for primary care and continued for specialty services. Practitioners in underserved areas will be eligible for tax credits. They will also get allowable depreciation expenses for medical equipment, and there will be safeguards to prevent discrimination based on race, ethnicity or gender.

The access initiative, which is a major element in title III of the Health Security Act, includes six interrelated approaches to overcoming existing barriers to care. These programs will help assure that all Americans, including those living in inner-city and rural areas, not only have access to the full range of services, including the comprehensive benefit package, but also will have an adequate choice of culturally sensitive providers and health plans.

Those six interrelated approaches include the continued funding and indeed increased funding for current safety net programs, such as Ryan White, migrant health centers, community health centers, homeless, family planning programs, changes in practitioner supply, particularly expansion of the National Health Service Corps, changes in graduate medical education, which would increase the number of generalists, and increased funding for primary care training for nurse practitioners, for physician assistants and others who could work in the rural areas.

Capacity expansion is, I think, critically important both for rural and inner-city areas; this would provide both loans, grants and loan guarantees to create practice networks in rural areas or inner-city areas.

Outreach and enabling services, things like transportation, translation, child care and outreach, would be expanded both through the community health center program and the other safety net programs and as an additional initiative, because they are areas that are not usually provided by health plans.

Increased support for mental health and substance abuse in the public health service programs along with the expanded mental health benefits in the benefit package would assure that individuals would have access to those services. Social supports and outreach would be necessary to help plans integrate those benefits and individuals to receive those benefits.

And then there are two programs for school age youth; one in an education program, and the second is school-related health services. These are particularly directed toward adolescents because they often, even when they are in health plans, don't utilize the traditional providers. One of the services that would be included would be psychosocial support and counseling services, which have been identified as a major need.

Finally, there are the core public health programs. We believe that as everyone is insured and the plans can relieve local governments of the financial obligations of providing care for uninsured individuals, that the local health departments and the State health departments can return to their basic public health function of protecting the health of the whole population. This is even more important for low-income individuals because they are more at risk to things like tuberculosis, communicable diseases, waterborne diseases, and other public health problems that would be dealt with through these core public health programs.

These programs include surveillance for communicable and chronic diseases that would help us define the magnitude and the source, for example, of a tuberculosis epidemic or, let's say, a chronic disease problem in the community so that the resources can be directed at dealing specifically with those problems, programs to control communicable diseases and injuries, environ-

mental protection, public education and community mobilization, accountability and quality assurance.

Here the State health departments and indeed the local health departments can help assure plan performance in terms of achieving public health objectives. Public health laboratories would also be an essential part of this, as would training and education of public health professionals.

And finally, true research areas, prevention research at NIH and outcomes effectiveness research and health services research at the Agency for Health Care Policy and Research. These are all inter-related initiatives that we think would strengthen the capacity of the system which, without a real attention to the infrastructure and organizational issues, really with just the health security card, will not meet the needs of rural and inner-city areas.

Let me just close then, Mr. Chairman, by emphasizing that the President's Health Security Act is designed to provide all Americans, including those living in inner-city and rural neighborhoods, with real health security at an affordable cost. To this end, the public health initiatives in title III are not separate from, but rather integral to the success of health care reform.

Thank you for the opportunity to be with you and I am pleased to respond to any questions.

[The prepared statement follows:]

**STATEMENT OF PHILIP R. LEE, M.D.,
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Good morning, Mr. Chairman and members of the Subcommittee. I welcome this opportunity to discuss how the President's Health Security Act will meet the health needs of rural and inner city Americans.

Mr. Chairman, you and others in the Congress have been eloquent in speaking out about the health crisis facing our inner cities and rural communities. Indeed, these areas epitomize the problems and consequences of **health insecurity**. Compared with other parts of the country, rural areas and inner cities have a greater proportion of uninsured people; fewer, and often poorly qualified health care providers; inadequate outpatient and inpatient facilities; and a paucity of economic resources to create effective networks of care. Although the need for health services is great in these communities, many residents face substantial geographic and cultural barriers to obtaining care. In addition, they suffer from a disproportionately high burden of preventable disease and injury. The costs of these health problems have been staggering, both economically and in terms of human suffering.

The President's plan provides the means -- for the first time -- to make health security a reality for all Americans, including those living in rural areas and inner cities. It does so not only by assuring all Americans comprehensive insurance coverage, but also by building up the capability of rural and inner city communities to overcome barriers to care and to protect and improve the health of their residents.

THE HEALTH CARE PROBLEM IN RURAL AREAS AND INNER CITIES

Obtaining affordable health insurance is one of the most glaring problems for inner city and rural Americans. In the District of Columbia, for example, one in four residents under age 65 does not have health insurance. More than 8 million rural Americans have no health insurance, including 18 percent of all farm families. Because they generally lack the benefit of being part of a large business or purchasing group, rural Americans often pay more for health insurance than those living in other parts of the country. Some can purchase coverage through small employers or a rural cooperative, but many rural families have no choice but to purchase separate coverage at high market rates.

Even when rural and inner city residents are fortunate enough to have health insurance, many barriers still stand in the way of receiving proper medical care. In rural communities, barriers such as geography and lack of transportation present real challenges to health care delivery. With a relatively small population spread over a large area and health care professionals in short supply, patients often must travel long distances to see a physician.

Far removed from the support of their peers and the sophisticated equipment of their training facilities, fewer and fewer physicians are choosing to set up rural practices. Without enough doctors, nurses, and facilities, building networks of care becomes more difficult, as does the task of attracting or establishing enough health plans to foster choice and competition.

In inner cities, the challenges to obtaining access to care are different, though no less problematic. Crime, poverty, overcrowding, unemployment, and violence make the inner city an unattractive environment for health professionals. Ironically, many inner city neighborhoods are located only a few blocks away from some of the world's most renowned academic health centers, yet the number of physicians willing to practice in these areas has dwindled in recent years. One study by the Community Service Society of New York found only 28 properly qualified physicians serving a population of 1.7 million people in low-income neighborhoods in Harlem, north central Brooklyn and the South Bronx.

In addition to the scarcity of providers, the quality and accessibility of care is also a serious problem for inner city patients. Of the 701 generalist physicians practicing in Harlem, Brooklyn and the South Bronx, only 28 or 3.9% were found to meet minimum standards for providing adequate primary care. Many refused to accept patients on Medicaid, were open for less than 20 hours a week, and did not offer emergency after hours care or have admitting with any hospital.

Practitioners in inner cities are also frequently ill-prepared to meet the cultural and linguistic needs of their diverse patient population. Rarely do these environments produce physicians from their own communities. Consequently, patients and providers generally come from vastly different backgrounds.

The lack of health insurance and other barriers to care have contributed to the poor health status of many residents of rural and inner city communities. Let me give you just a few examples of the disproportionate share of preventable illness and injury these populations bear and the costs of these problems to the health care system.

- Cancer is diagnosed at much later stages in inner-city populations, often when it is no longer treatable. In Harlem, for instance, only five percent of women with breast cancer are diagnosed at an early stage as compared with 42% of African American women and 52% of Caucasian women nationwide. The Centers for Disease Control estimates that the direct medical costs of treating breast cancer rise from \$25,000 to \$84,000 per individual when detected late instead of early.
- From 1985 through 1992, while the tuberculosis case rate declined from 6.7 to 6.5 cases per 100,000 in non-urban areas of the United States, it increased from 17.1 to 22 cases per 100,000 in urban areas. Currently, New York City accounts for 14 percent of all cases of tuberculosis in the country. In Harlem, the prevalence of tuberculosis is 200 cases per 100,000, four times higher than the New York City average. The Centers for Disease Control estimates that \$480 million per year will be required to curtail the emerging tuberculosis epidemic.
- HIV/AIDS is a serious problem in inner cities, but it is also becoming more prevalent in rural areas. In North Carolina, for example, HIV infection has increased at an alarming rate, with 75 percent of new infections occurring among low-income minorities in rural as well as urban areas of the state. The cumulative cost of treating all persons with HIV is forecast to be \$15.2 billion in 1995. Yet each case of AIDS that can be prevented can save approximately \$102,000 in health care costs.
- Rural areas have an inordinately high rate of serious accidents due to the risks of farm, mining, and other occupations. Over a three year period in Iowa, CDC's National Center for Injury Control reported 7,797 farm injuries, resulting in 1,263 hospitalizations, and 236 deaths. The Center for Agriculture Disease and Injury Research, Education, and Prevention at the University of Iowa estimates that preventing the 140,000 disabilities caused by farm accidents each year in the United States would save \$3.6 billion.

BENEFITS OF THE HEALTH SECURITY ACT TO RURAL AND INNER CITY AREAS

This morning, I would like to go over those aspects of the President's plan that will provide inner city and rural Americans with real health security. After reviewing some of the basic elements of the reform, I will concentrate on the public health initiatives contained in Title III of the Health Security Act that are designed to assure all Americans -- including those living in underserved areas -- access to medically necessary and appropriate care when they need it, and to enhance the ability of all communities to protect, preserve, and promote the health of their residents. These programs, which are integral to achieving the goals of health care reform, will ultimately determine how well we improve the poor health status of many inner city and rural Americans and the extent to which we will be able to contain our nation's escalating health care costs.

Basic Elements of Reform

I need not review in detail with this committee the basic elements of the President's plan that will improve access to care for all Americans. However, considering the special problems of inner cities and rural regions of the country, several points are worth emphasizing:

- Under reform, all Americans will be covered for a comprehensive range of benefits, including expanded mental health and substance abuse services. In addition, preventive services will be available without deductibles or copayments.
- Health care alliances will provide consumers with the purchasing power many currently lack to bargain for lower premiums.
- Indigent populations will receive subsidies to cover part or all of the costs of premiums, cost sharing, and, in some cases, wraparound services.
- The self-employed, including farm families throughout the nation, will be able to deduct 100 percent of the cost of their health insurance premiums instead of the current 25 percent.
- Small businesses will be eligible for premium discounts, further stretching their health care dollars.
- Providers no longer will receive lower payments when they care for low-income patients. Medicare's bonus payment for physicians practicing in underserved areas will be doubled for primary care physicians and continued for specialists. Hospitals serving a high proportion of low-income and undocumented persons will receive additional payments through a federal Vulnerable Population Adjustment.
- Practitioners providing care in underserved areas will be eligible for tax credits of up to \$500 per month for nonphysician providers and \$1,000 per month for primary care physicians. The allowable depreciation expense for medical equipment also will be substantially increased for these providers.
- Safeguards will be implemented to prevent discrimination based on race, ethnicity, age, or gender. These include prohibitions against cherry picking and redlining, enforcement of Title VI of the Civil Rights Act, requirements that alliances not subdivide metropolitan statistical areas, and the ability of States to require health plans to include inner-city or rural communities in their service areas.

Access Initiatives

Congress, including members of this subcommittee, has demonstrated great concern about the ability of underserved populations to obtain access to personal health care services. You have also expressed concern about the ability of health care providers currently caring for underserved populations to participate successfully in the reformed system. The President recognizes, as you do, that a Health Security Card will not, in and of itself, guarantee that all Americans receive appropriate medical care. To achieve this goal, universal health insurance must be backed up by an adequate system of practitioners, facilities, education, outreach, and information.

The Health Security Act uses six interrelated approaches to overcome existing barriers to care. These programs will assure that all Americans -- including those living in inner-city and rural areas -- not only have access to the full range of services included in the comprehensive benefits package, but also will have an adequate choice of culturally sensitive providers and health plans.

- **Current Safety-Net Programs.** First, current safety-net programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained and strengthened under reform.

Providers funded under these programs will receive automatic designation as *essential community providers* for at least five years. This will guarantee them payment for covered services from all health plans. Equally important, it will assure that vulnerable populations have continuing access to practitioners with experience meeting their special needs, regardless of which health plan they choose to enroll in.

- **Practitioner Supply.** The supply of practitioners in rural and urban underserved areas will be increased in several ways under reform. The National Health Service Corps will be expanded approximately five-fold from its current field strength of 1,600. Residency training will be redirected to increase the ratio of primary care physicians to specialist physicians from about one-third to 55 percent. Support for training programs for primary care physicians, physician assistants, and advanced practice nurses will be doubled.

Special programs to increase the representation of minorities among health professionals will help to overcome access barriers that stem from cultural gaps.

- **Capacity Expansion.** Capacity expansion in inner-city and rural areas will be actively supported both by expanding the successful community and migrant health center program to provide services to an additional 2 million individuals and through a new competitive grant and loan program supporting the development of community-oriented practice networks and health plans.

The new program is designed to integrate federally funded providers with other providers in underserved areas, bolstering their ability to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in underserved areas by creating new practice sites for 3,800 additional practitioners and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural underserved areas -- and improve coordination of care -- by linking providers in practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

Grants and loans under the new program will be made to groups of providers working

in medically underserved areas or caring for underserved populations. In making awards, preference will be given to groups that include the maximum number of different types of federally funded providers and that link these providers with those not supported by public funds. All providers included in the community practice networks will receive automatic designation as *essential community providers*.

- **Outreach/Enabling Services.** The Access Initiative also incorporates a new competitive grant program that will expand federal support for enabling services, such as transportation, translation, child-care, and outreach.

These grants will help 6 million isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care. They will also help individuals who have been denied access to the current medical care system shift their care patterns away from emergency rooms and receive earlier and more appropriate primary care services.

Awards in this program will be made to community practice networks, community health plans, and other public and private not-for-profit organizations (such as community health centers) with experience and expertise in providing outreach and enabling services for underserved populations. These grants will supplement support for enabling services provided through existing Public Health Service programs.

- **Mental Health and Substance Abuse Initiatives.** The Health Security Act also includes new funds to assure that low-income, hard-to-reach individuals know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package.

Working through the existing Community Mental Health Services and the Substance Abuse Prevention and Treatment formula grants, these funds will support enabling services -- community and patient outreach, transportation, translation, education -- for 2.5 million low-income individuals and other vulnerable groups (such as the homeless or the severely mentally ill). In addition, they will build up the currently inadequate infrastructure for delivering mental health and substance abuse services in communities and facilitate integrating these services within the broader health care system.

- **School-Age Youth.** Finally, the Access Initiative incorporates two new programs to reach out to one of our Nation's most vulnerable groups -- school-age youth and adolescents. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior -- to up to 3.2 million children in over 3,500 schools or school-linked sites. Grants will be made to states for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organizations.

Core Public Health and Prevention Initiatives

Most of the health care debate has focused on the personal health care system. But, without question, the burden of illness in inner cities and rural areas is directly related to our lack of support and attention to public health. In 1982, the Institute of Medicine estimated that only 10 percent of preventable early death is related to inadequate delivery of personal medical services, whereas 70 percent is related to environmental and lifestyle factors that can be addressed by public health. In recent years, however, as the health insurance system has failed more and more Americans, public health's energies and resources have increasingly been focused on providing personal health care services to the uninsured and underinsured, to the detriment of its essential, population-based functions.

To improve the health of inner city and rural residents we must define the particular groups for whom health problems are most common. We must identify effective interventions by learning why some communities are hard-hit by a problem while others somehow seem to escape. We must target public education and prevention interventions to populations at highest risk and populations with different cultural backgrounds. And we must create alliances between public health agencies, health plans, and providers as well as sectors outside health, such as public schools, law enforcement agencies, and social service agencies.

By guaranteeing all Americans universal coverage, the Health Security Act provides public health agencies with the opportunity to refocus their energies on protecting the health of the residents in their communities. Two programs included in Title III provide the public health system with vital support to achieve this goal.

- **Core Public Health Program.** This competitive grant program will provide funds to State health agencies to strengthen the following essential public health functions at state and local levels:
 - (1) surveillance of communicable and chronic diseases -- essential to define the magnitude, source, and trends of health problems so that limited resources can be directed to populations at greatest risk.
 - (2) control of communicable diseases and injuries -- essential to ensure that new problems are identified early, that contact tracing and partner notification occur effectively, and that sources of infectious exposures are removed.
 - (3) environmental protection -- essential to safeguard the physical and social environment (e.g., water, food, workplace, housing) against causes of disease.
 - (4) public education and community mobilization -- essential to prevent major causes of premature death and disability that are behavioral and societal in nature.
 - (5) accountability and quality assurance -- essential to protect consumers from medical and health services that do more harm to health than good.
 - (6) public laboratory services -- essential in the diagnosis of major infectious and environmental threats to health.
 - (7) training and education of public health professionals -- essential to ensure a workforce capable of carrying out public health functions.

The program fosters greater accountability to the federal government than has been realized previously for the definition and reporting of progress in achieving public health objectives.

- **Preventable Priority Health Problems.** A second competitive grant program will provide funds to public and private not-for-profit agencies to address health issues that affect local communities or specific populations within communities. Many of these problems do not affect the country uniformly and call for tailored, community-based interventions. For example, in some inner-city communities, diabetes or heart disease is a major problem; in others, priority may be accorded to programs that deal with cigarette smoking; while in still other areas, teen pregnancy is an issue of great concern. In cases where multiple factors contribute to a health problem, as with violence, grants will support approaches that cut across individual problems.

Among the initial set of priorities, the program will target prevention of smoking by children and adolescents; violence prevention; and reductions in behavioral risks that contribute to the incidence of chronic diseases, including heart disease, cancer, stroke, and adult-onset diabetes.

Prevention Research

Expanding the knowledge base can also help residents of rural and inner city areas, by elucidating new ways to improve access to care, prevent illness and injury, and control health care costs. This is addressed by the final components of the Public Health Initiative, which support a prevention research initiative in the National Institutes of Health and a health services research initiative in the Department of Health and Human Services.

Prevention research is the foundation for both clinical preventive services and the public health interventions included in the Health Security Act. Expanded prevention research will ensure the availability of effective preventive measures against existing diseases as well as new and emerging health threats. Progress in preventing disease will help to offset escalating acute health care costs and the disproportionate impact of disease and disability among women, minorities, and the elderly.

Health services research will elucidate what works best in medical care and how to organize providers and institutions most effectively in the new health care system. This investment will build on the considerable expertise of the Agency for Health Care Policy and Research in investigating outcomes and quality research, identifying practice variations with unnecessarily high costs, and developing practice guidelines to improve the appropriateness and effectiveness of the treatment decisions made by health professionals. Further development of these methods will provide more accurate measures to evaluate the performance of alliances and health plans and to assess the extent to which reform is making health care available to all Americans.

CONCLUSION

In closing let me emphasize that the President's Health Security Act is designed to provide all Americans -- including those living in inner-city and rural neighborhoods -- with real health security at an affordable price. To this end, the Public Health initiatives in Title III are not separate from -- but rather integral to -- the success of health care reform.

I appreciate this opportunity to appear before the Subcommittee and will be pleased at this time to answer any questions you may have.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Dr. Lee, as we look at the President's bill, indeed as we look at any comprehensive bill, there clearly are a number of areas of reform that need to be addressed. I guess my question to you would be, absent the mechanism for delivering universal coverage, let's set that aside. Let's just assume that it is done and not talk about how, OK? We have got universal coverage.

You then have a number of provisions in your bill that are either paralleled or augmented within a number of other bills. Let's assume that those components are agreed upon and we move forward.

In your estimation, how critical or essential is the concept of the alliance if we have got everyone covered and funded under a structure and we have got all of these support restructurings going on in terms of a drive for more primary care, educational structure, and the moneys on the outreach. We are moving particular identified populations under either managed-care concepts or other concepts.

If you just didn't do the alliances, wouldn't you make a major, major change? Or turn it the other way. Since you are in defense of the administration's position, does none of that matter if you can't get your alliance structure, your forced redistribution structure?

For most Americans, these folks are people that are left out to a certain extent. Most of these programs are pickup programs to bring them into the structure. How critical, in your estimation, are the alliances to delivering that changed service?

Dr. LEE. Well, I do support, obviously, as a spokesperson for the administration, the alliance concept, but I also personally happen to strongly support this idea for two reasons particularly.

One, because it gives low—people who don't have access to the market the purchasing power. In other words, it is a purchasing cooperative on behalf of people who work for small employers or individually employed individuals, and when you see what some larger organizations can do to assure their employees the competitive benefits in terms of quality and price, that is a significant benefit.

The other benefit to me—

Mr. THOMAS. I think on that point, doctor, that makes some sense in urban areas. For example, in the area that I represent, frankly, no managed competition, no forced competition model is going to work. We are looking at some clinics and some other government-involved structures to really flesh out the health care delivery system.

So although a lot of us either in voluntary purchasing cooperatives in the Chafee-Thomas bill or the mandatory purchasing cooperatives, that concept makes some sense and that is the point that you just spoke to in terms of the alliance. But how does the concept of the alliance work in a county of 17,000 people like Inyo County, which is the second largest geographical county in the United States? I mean, it is not going to work there, right?

Dr. LEE. I would say, to me, the second—and I will speak to that also. The second advantage of the alliance is that it focuses on a geographic area that contains a population, so it is population based. It then permits, within the alliance area, a focus on achiev-

ing public health objectives within the plans, as well as within health departments.

For example, with the immunization or other of the provisions in the plan, it permits us to look at the population within that area to see how well we are achieving those objectives with whatever plan is in the area.

Now, in underserved rural areas or sparsely populated areas, as the Sierra Counties in California, for example, it is my understanding currently, with the purchasing cooperative in the Mr. Mid program in California, that in those areas, they have basically a fee-for-service plan that is the plan that is available in those areas.

And there does have to be in each alliance area, at least, a fee-for-service plan. With the augmentation of the access initiative, which would permit increased funding for resources with the changes in training programs, both nurse practitioners and physicians, hopefully we could get more physicians and more nurse practitioners into those areas with the development of practice networks through the access initiative.

We should be able to enhance the services that are available to individuals in Inyo County or some of the other sparsely populated counties. So I think it is a combination of things. The alliance is only one element in that.

Mr. THOMAS. But in the testimony before this committee from the administration on the purchasing cooperatives—on the alliances, I think the administration was shocked to find out that the voluntary purchasing cooperatives in California in terms of the regional units aren't even necessarily contiguous; that, in fact, they make up like components in different geographic areas of the State.

Is there anything in the Clinton bill that would allow these services, as you have outlined them, within an alliance to cross State lines?

Dr. LEE. Well, I think—

Mr. THOMAS. For example, western Nevada, believe it or not, looks to the urban area of Inyo County, which is, we just outlined, a very difficult area to deal with, for their support. Does the Clinton bill envision these networks crossing State lines?

Dr. LEE. The networks could cross State lines, and also, of course, the plans could cross State lines—

Mr. THOMAS. The alliances could not?

Dr. LEE. No, the alliances could not, but the plans absolutely could, and there are many situations similar to that. If you look at, say, North Dakota which serves a lot of patients from Minnesota, or if you look at Delaware, I think 40 percent of the patients there are not residents of the State.

So the plans can cross State lines and integrated delivery systems could certainly do that. They would obviously have to be licensed in each State, and the insurance plans would have to be licensed in those States. But as the insurance system now works, somebody living in Connecticut, for example, can go to New York to get their care, or somebody living in Nevada can go to California to get their care.

This simply extends that insurance coverage to cover those who don't have insurance, and I don't see that it would limit that plans capacity to cross State lines if it chose to do so.

Chairman STARK. If a plan chose?

Mr. THOMAS. If it chose to do so, which is a statement that I think in terms of the way in which they are going to be structured, perhaps enormous ifs. This goes back to what I consider to be one of the fundamental flaws in the alliance structure, but my concern and direction is that I think a number of items that are contained in the President's bill clearly are good and worthy in terms of expanding health care needs to inner-city, urban and rural areas, but that they are also contained in a number of other provisions, and that all of these items probably need to be addressed more or less, regardless of either the funding or the delivery mechanism.

They are long overdue, especially in the area of communicable diseases and some of the preventive things that we need to do, and I appreciate your testimony.

Dr. LEE. Thank you very much.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman. I want to follow up on the line that Mr. Thomas was exploring and that is the whole question of alliances and the outlines of them. Right now you have a great controversy on the front page of the Washington Post today about Tennessee Care and what is happening in rural areas and where do you have doctors and can you get somebody to sign up and so forth.

And as I look at the alliances, one of the real problems for me is the whole question of the standard metropolitan statistical area. Everybody says you can't split them and I hear people walking around saying, well, I don't know, maybe you should be able to split them. And my concern is that if you could take a standard metropolitan statistical area and split it and drop out 4 or 5 ZIP Codes, you can probably make it a pretty profitable place, certainly could in Seattle.

I could tell you which Zip Codes to drop and you would probably—I could probably get six or seven insurance companies who want to come into Seattle.

Where I used to live on the west side of Chicago in West Garfield Park, there isn't any insurance company on the face of the earth that is going to eagerly run in to take that part of the city.

And my question to you is this: If the bill passes that has any kind of split in standard metropolitan statistical areas, would you recommend to the President that he veto the bill?

Dr. LEE. Is that a total bottom line issue? The President has indicated—

Mr. McDERMOTT. It is a bottom line issue to cities, because if you are going to allow cities to be fractured in any way so that anybody can leave out the tough parts and get the good parts, you are going to have the same cherrypicking—you are going to have redlining in health care. From a citizen who lives in a city, represents a city, it is a bottom line issue, because if they are going to split them, then we are back right where we are right now. We haven't gained an inch.

Dr. LEE. Well, as you know, if the President has indicated coverage for everybody, comprehensive benefits, are the bottom line issues, my own view—again, you asked me would I recommend that he veto it. I would agree with you that this is a fundamental issue,

that everybody has to be assured access to medically necessary and appropriate care, and if you exclude geographic areas—one of the things we are trying to get away from, clearly, and one of the problems today, is redlining.

There are a number of other pernicious practices by the insurance industry that need to be eliminated. In this case, the alliances are required to include the SMSA in the alliance area. And my own view is that is the way it should be.

I would say it would be a tough call whether it should be vetoed on that basis alone, but I think it is an issue that the President should take a very strong stand on.

Mr. MCDERMOTT. Because I anticipate that an amendment slipped in at the end in the conference committee. That is where I think it will happen and I think it is one of the reasons why the single-payer system is the only way to go so that you then have everybody in the same system. If you allow this system to be put together and at the end, at the very end you slide in an amendment, as sometimes happens around here, you wind up perpetuating one of the major problems we have in our cities and that is the failure to deliver of health care to the real tough inner-city areas, and I think it is an issue that needs to be on the table, needs to be in the record, and it needs to be thought about very hard by all members.

Dr. LEE. Of course, there is the option in the Health Security Act for single-payer. There is even an option for single payer in an urban area, so that you could do that in a particular urban area if that seemed to be the best solution.

But I would also think with the chairman participating in the conference committee, we should be able to preclude that kind of language from being slipped in at the last minute.

Chairman STARK. Thanks for the endorsement.

Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Dr. Lee, I would like for you to explain the President's proposal to support essential community providers. I understand that essential community providers will be covered automatically in all health plans for 5 years. I would like to know why the coverage ends in 5 years.

What is the rationale for ending this coverage in 5 years?

Dr. LEE. The essential community providers will be automatically continued for 5 years. It would then be reviewed at that point, and probably a year ahead of time, before any decision was made to terminate it. And if it was determined that there would be impaired access if that requirement weren't continued, it would be continued.

In other words, we would want to assess the access to care, the quality of care, the appropriateness of care through that mechanism. I would presume by that time we would see the development of the practice networks and the essential community providers would be integrated into either their own plans or broader based plans, and you would not need to continue that particular requirement. But it would be required, as we are currently proposing it, to review that prior to any termination of the requirement.

Mr. LEWIS. Let me just ask you about another area of great concern to me, Dr. Lee. How would the President's proposal provide mental health and substance abuse coverage for a low-income community, especially those in the inner cities?

Dr. LEE. The standard benefit package, of course, includes some benefits, significantly beyond what many plans currently include. We would also continue the funding through the Public Health Service through State and local governments for both the mental health and substance abuse provider network that is there currently, requiring the States to develop a plan to integrate the private and public systems so that we would see how that could be achieved once full benefits were provided after the year 2001.

There would also be in the interim an expansion of support. Increased support is proposed in title III of \$250 million a year to strengthen the outreach and enabling and support services for that population, because we recognize that for some of the chronically mentally ill, particularly those with dual diagnoses and those who are, for example, homeless, the kind of safety network we have needs to be continued, needs to be strengthened in order to assure the chronically mentally ill population, particularly, access to these services.

Mr. LEWIS. Dr. Lee, is it possible for the proposal to go the second mile and do something extraordinary, out of the ordinary in rural areas and inner-city areas where people have been left out and left behind so long when it comes to delivery of health care?

Dr. LEE. Well, I would say many of those people, of course, are uninsured, so providing insurance for everybody is going to be fundamentally important, and a comprehensive benefit package. But the capacity expansion and the other access initiatives, we think, will be a major element in assuring individuals real access to care in addition to just being covered with insurance. In addition, the development of practice networks in inner-city areas and more training of family physicians and nurse practitioners and physician assistants, the development of practice networks through the access initiative, and potential, at least in fee-for-service plans, increased payments.

Certainly that is going to be true in Medicare, for primary care in underserved areas, and that would include rural areas, with the development of—in rural areas, particularly—telecommunications links, so that the professional isolation that is there would be diminished, and the development of enabling services and outreach, things like transportation.

In rural areas, a very significant percentage of elderly patients, for example, don't have access because they do not have an automobile. I was just out in New Mexico visiting a number of Indian reservations, and one of the primary problems they described in terms of access to care was lack of transportation, particularly when the weather is bad. Poor roads, very rurally isolated.

Transportation is an important element, so those outreach and enabling provisions in the Health Security Act would help to develop the capacity in those areas to help meet these needs in a very real way.

Mr. LEWIS. Thank you, Dr. Lee.
Thank you, Mr. Chairman.

Chairman STARK. All right, Mr. McCrery.

Mr. MCCRERY. Dr. Lee, I am sorry I missed your presentation in full, but I need to ask you a couple of questions. We currently have a system, the Medicare system, and to some extent the Medicaid system, that at least in some respects resembles what the Clinton administration is trying to do with the rest of the health care system. That is, in the Medicare system, we have budgetary constraints and we, from time to time, adjust reimbursement levels and pretty well dictate what providers are reimbursed for services in that system.

Is it not so that the Clinton plan would essentially impose that on the rest of the health care system through its global budgets, its premium caps, and the regional alliances' budgets?

Dr. LEE. I think that the proposal by the President differs significantly from the current Medicare and Medicaid programs. Medicare is largely fee-for-service, although there are some capitated, pre-paid plans, a relatively small percentage of the Medicare population.

Medicaid, as well, has a relatively small percentage in managed care, although that number is increasing.

What the President has proposed is the development of integrated delivery systems that would provide comprehensive care with a major emphasis on quality. We could look at the evolution of some of those systems in recent years, and I would use Kaiser Permanente in California as an example.

In talking with David Lawrence, who is the CEO; he tells me that they are able to reduce the rate of increase in expenditures or reduce the premiums that they charge principally because of the improvements in the quality of their care, which was developed through a comprehensive, continuous quality improvement program over the last 5 years. So quality is a major component in these plans, and it is within the plan.

Now, you will competition between the plans. Medicare is paying individual physicians or individual hospitals. It isn't competition, except for the HMOs which between plans.

The premium cap is in a sense a fail-safe. In other words, if the competitive plans do not achieve reductions in rates of increase in expenditures, that is there as a fall back protection, and to ensure that we can achieve a long-term slowing in the rate of growth in medical care expenditures. So it is more in a sense of a backup, not as primary.

The primary approach is plans competing on the basis of price and quality, and the premium cap and the global budget would be backup mechanisms. That really differs quite significantly from Medicare. The capacity wasn't there to have competition, so Medicare instituted the DRGs in 1983 and passed physician payment reforms in 1989, which had significant effects on slowing the rate of increase. The President looked at that approach and did not favor that approach, but rather this managed competition approach, which is really a different way of trying to achieve the same objective.

Mr. MCCRERY. Explain to me how the subsidy caps would work in conjunction with the premium caps.

Dr. LEE. How would the—I just want to make clear what is your—

Mr. MCCRERY. As you know, the Government is going to subsidize businesses under the Clinton plan.

Dr. LEE. You mean small, low-wage employers, which have a 3.5 percent limit for the—

Mr. MCCRERY. Anything over those. The Government is going to subsidize, and the Government is going to cap those subsidies. So how does that fit into the premium caps? How do they work together?

Dr. LEE. The studies that have been estimated by the economists and the actuaries estimating what it will take in terms of a premium, at what level of employment to achieve the necessary resources to fund the program. In other words, what is it going to take from individuals and from employers. We could certainly get from Ken Thorpe or Judy Feder the sort of methodology and all the figures to provide that in a more detailed way, but—we believe very strongly that managed competition will, in fact, slow the rate so that there would not need to be additional Government subsidies.

I certainly believe that. I think we can bring down the rate of increase in expenditures. If we look at what has been happening recently, whether managed care has had a lot to do with that or not, we have seen a significant slowing of the rate of increase. We have certainly seen that in Medicare. So I believe we can bring those costs down, and I think that other people agree with that, as did the outside actuaries who looked at the soundness of the financing mechanisms, that the subsidies would be sufficient, and that we could achieve the kind of cost containment objectives that are outlined in the plan.

Mr. MCCRERY. I appreciate that, but the fact is—

Dr. LEE. But there clearly is disagreement and other people don't—

Mr. MCCRERY. And I don't necessarily disagree, but clearly I don't know, nor, I would submit, does the administration.

If they don't work, if those market forces don't work, then it is clear to me that the Government is the ultimate arbiter of what eventually gets into the system, and we are here today to talk about rural health care, and, again, I would submit that one of the primary problems today with maintaining a base of rural health care infrastructure is the reimbursement system that has been imposed on those providers through the Medicare and Medicaid systems, and they are cost shifting.

They are attempting to cost shift in rural areas to not much avail because most of their patient load is now Medicare or Medicaid. So if we are not doing very well providing services in the rural areas as a result of a current government program, I just question whether putting the rest of the system at the whim of the government in terms of reimbursement and total cost of the system is going to do much better for the rural areas of this country.

Dr. LEE. Well, it is, I think. One of the problems in rural areas, of course, is the large number of people who are uninsured. In the Medicare program, it is intended to raise the payments for under-

served areas for primary care services, to increase the incentives. So there will be several policies in terms of just the payment.

We know that payment doesn't do it alone. There are a lot of other factors in rural practice and rural areas that result in physicians not wishing to settle in rural areas, not the least of which is the opportunity for their kids to go to school. So these—

Mr. McCRERY. That is true, but in my area though, the primary problem with rural hospitals going out of business, shutting their doors, is not being able to pay for all the services that they have to provide, and that is primarily as a result of the reimbursement system with Medicare and Medicaid, and the heavy patient load with Medicare and Medicaid.

Now, it may help to insure all the uninsured in the rural areas and then they would have more people to cost shift on, if they could depend on that cost shift. But under your plan, they would be looking at the same situation, then, with the private pay patients as they are with the Medicare and Medicaid. They would be looking ultimately at the reimbursement level being controlled by budgetary considerations of the government.

Dr. LEE. Well, in the President's plan, the goal is to have that not controlled by the Government, although the premium cap is a backup, but rather to have quality be the principal thing that drives it, and with competition, hopefully achieving the cost containment objectives that are outlined in the plan.

Mr. McCRERY. Thank you.

Chairman STARK. Jim, you ever seen a shooting star late at night flash? Watch tomorrow evening, OK?

Dr. Lee, I was interested in your exchange with Mr. Lewis and I was intending to talk with you about the sunseting of the redlining or essential community providers. So I assume from your answer is you said that you wouldn't want to see that happen and these communities be left, bang, at the end of 5 years without these essential community providers.

Dr. LEE. Absolutely.

Chairman STARK. So I assume that the administration would therefore support our just making a little change and say, we will review it and at the end of 5 years and we won't have it automatically sunset, and then if you can convince us it is no longer necessary, we will eliminate it. Would you support that?

Dr. LEE. I would say if Congress judges that is the best way to go, I would certainly not object to that at all.

Chairman STARK. Great. Now, one other test. I would like to join in on this cost saving, but Mr. McCrery has done an excellent job on that. I am concerned, again, on this underserving the inner-city and rural areas. The Public Health Service insofar as they have been able, has done a very good job, but in the President's program, let us focus ahead and pretend that we are in 1998. Leon Panetta survives as budget director and we are all here and we have a zero sum budget game and we have a freeze on discretionary spending and the plan that you have outlined for having the Public Health Service requires something we are not used to in this committee.

It requires an appropriation of exactly \$48 billion. The first year it is only \$1.1 billion. How would you recommend to us that we cut the President's budget, which is going to be presented to us tomor-

row, by \$4 billion to fund the program that you are suggesting? What areas do you think we should cut in—just to give you the order of magnitude. This is a year. Where would we cut \$4 billion out of discretionary nondefense, because we can't crossover into that arena. Where would you just guess that there is an extra \$4 billion to continue to provide the community and migrant health centers that are going to be necessary?

Dr. LEE. In 1995, Mr. Chairman, the \$1.1 billion is mandatory spending outside the discretionary caps. Currently—

Chairman STARK. But it isn't in 1998 when it is \$4 billion.

Dr. LEE. I know, but the administration is committed to working with Congress to insure that the public health initiative is funded, so that I think the 1995 approach at least suggests this is one way to go. And we would work with Congress until that is identified and the assured funding is there.

Chairman STARK. How about space? Want to cut the Supercollider? NASA? Roads? Mass transit? Education? Where are we going to get the \$4 billion? I am just trying to figure this out.

I want to show you what we are up against in 1998 when many of us hope to be back here. We still have the program that Mr. Lewis is concerned about, but in order for community health centers and migrant health centers to continue in the central valley of California, they need \$4 billion. We are not talking about \$40 million—\$4 billion. Where are we going to get it?

Dr. LEE. Well, the funding, this secure funding, which has been achieved in 1995, as employed in the Health Security Act, would be outside the budget caps, outside the discretionary spending caps, so that the Congress would not have to make those kinds of decisions.

Chairman STARK. The first year.

Dr. LEE. Well, no, even through the whole period. The administration is committed to working with Congress to identify that source of funding and to assure that it is there, and it is already there for the first year.

Chairman STARK. We are committed to national security, to national education, to clean air. We are overcommitted up here. I mean, we have commitments out there that we aren't going to be able to pay for for 100 years.

Now, the point is that I am afraid what you are telling me is that we are going to have to compete with nonhealth discretionary programs and, in fact, other health programs for that \$4 billion, are we not? There is no guaranteed funding in there for that any more than you are guaranteeing educational grants or any more than you are guaranteeing to pay for these thousands of cops you are going to put on the street. That is not guaranteed. That is going to have to come up against the appropriation process.

Dr. LEE. But the administration would work with Congress to identify the secured source of funding that would be not under the discretionary cap, so it would not have to compete with education or other health programs or Head Start or things of that sort that would be under the discretionary cap.

Chairman STARK. Where might that be? I don't know any—

Dr. LEE. If you look at the budget and the financing for the Health Security Act, there are several areas where that might come from.

Chairman STARK. Like what?

Dr. LEE. Well, if you look at the total budget, you have got tobacco tax in there. You have got various savings potentially.

Chairman STARK. You want me to take it out of all—remember, this is 1998. You have already had me take \$154 billion out of Medicare.

Dr. LEE. I am not talking about Medicare because that money is specifically to benefit the elderly. You are not going to do that.

Chairman STARK. No, it isn't specifically for the elderly and you know that. Come on.

Dr. LEE. I think the intention is that the Medicare savings are going to be used to produce benefits for the elderly.

Chairman STARK. That is not the case. There is nowhere near that much additional benefits for the elderly in this program. Define for me 154 billion dollars' worth of additional Medicare benefits in this program. I mean, it is nowhere near that. It all goes to pay for the poor. You are cutting the benefits for the elderly to pay for the poor and to subsidize low-income workers.

Dr. LEE. You are not cutting the benefits for the elderly. You are slowing the increase in expenditures to providers.

Chairman STARK. Not your plan, not with \$154 billion. Remember, we had the discussion, you can't get Medicare until Carol gets it. I can't get it until I am 101. You don't think that is cutting my Medicare benefit? Of course it is.

Dr. LEE. We are still assured comprehensive coverage.

Chairman STARK. But not at the cost. I have already paid for my Medicare, just about. I don't have many years to go, and I want it. And you guys are trying to postpone it for a time beyond which I am not certain that I am willing or able to wait.

Well, I just wanted to point out to you that when you depend on appropriations, as you do, there is no guarantee that those provisions will be there, and it does concern us.

I think that Mr. McCrery was kind enough to let you off the hook, but if these States run short on providing for what has basically been a Medicaid responsibility, they have got to come back here for an appropriation if they run out of money halfway through the year, and that is not to suggest that Congress might not do that, but our record hasn't been too good and I am concerned.

The only other issue is the question that your alma mater asked me to raise because they are worried. You basically knock the disproportionate share, you reduce it by about 75 percent. Stanford wants to know how you expect them to survive when they have told me recently they have been underfunded for providing care to the poor and—how are we going to fund these tertiary care centers, whether it is in San Francisco or Palo Alto, Oakland, if you are going to knock them in the head 75 percent the first year?

Dr. LEE. Well, I would say, first of all, you need to take a very careful look at, let's say, an individual institution and see if they will provide you with the data on what their revenues, in fact, have been and rather than accepting their assertion, to really look at the data from those institutions. Because I think that what we want

to do is to provide the Congress with the most accurate information on which to make these judgments.

On the disproportionate share, the Medicare disproportionate share, about 78 percent that they are estimating is related to uninsured, and 22 percent is related to low income.

Chairman STARK. Right.

Dr. LEE. And that, as I understand it——

Chairman STARK. That is the 78 percent you are going to cut.

Dr. LEE. Right, right, right. Now, Stanford presumably would then have all these uninsured, that they are presumably taking care of, covered.

Chairman STARK. Let me try this. Because I don't believe you.

Dr. LEE. Plus we have the academic health center fund that would provide additional funds for them.

Chairman STARK. That isn't enough. Let's take the District of Columbia and you are going to put 200,000 people, new, into some managed-care plan, managed care meaning that some guy is going to make a profit because you anticipate that these will be profit-making entities by holding down the cost of care, and let's even assume it is Kaiser, but in this neck of the woods, Kaiser doesn't have knocks on salary and it doesn't own its own hospital hospitals, so it is contracting, OK?

It is contracting with providers in the district and it is contracting with hospitals and they got a case that should go to Johns Hopkins. They are not going to do it. They would lose the revenue and the minute the patient goes to Johns Hopkins, Johns Hopkins is the gatekeeper and Johns Hopkins is going to do all the x rays over again and they are going to want their own MRI study and their own blood workup and their own physicians to do the primary workup, and Kaiser knows that so Kaiser is going to say, no, we are going to keep those people here with our providers, and Johns Hopkins, as does Stanford, as does Mayos, is going to get cut off from a substantial part of the referral business they now get because the managed-care people will not spend the money.

I don't care whether they have been paying 1 percent of their premiums as a tax to support them. That is just lost money to them. They still have to pay the entire freight to Johns Hopkins if they refer a patient there and you have got to make a case why somebody who is holding out to themselves for their own professional comfort, that they have adequate staff and specialists and adequate staff of primary care and an adequate staff of hospital service, why are they going to refer anybody?

They would admit to themselves that they are no good? You and I know that isn't going to happen. So I am submitting to you that not only while you may get these disproportionate share of people paid for, they are going to be paid for to a plan that we recognize today is not as good as these specialty centers and they are going to wither on the vine. That is their worry and I share the worry.

Dr. LEE. Well, there are several things in the plan; I would say two things. One, we need to look at what is going to happen if the plan isn't passed past and people aren't insured and we have a continued deterioration in the system——

Chairman STARK. In what regard?

Dr. LEE. If the present trends continue, more people would be uninsured, fewer people able to access care, so that those centers which are taking care of more and more uninsured have greater and greater difficulty doing that.

Chairman STARK. That wouldn't happen if we put people under Medicare though, would it?

Dr. LEE. If you have everybody insured.

Chairman STARK. Under Medicare.

Dr. LEE. Through whatever mechanism, it wouldn't happen, whether it is the President's plan or single payer.

Chairman STARK. If you put them all in Humana, they are never going to see Hopkins or Stanford or Mayos or any of the other medical centers because Humana, you and I know, won't spend the money.

Dr. LEE. I won't speak about Humana, but let's just speak about—you mentioned Kaiser. In California certainly—

Chairman STARK. That is different. At Kaiser they own the hospital. They have got the doctors on salary and they might on occasion refer out. But here they don't have that luxury and they are going to have to use whatever hospitals that can remain nameless in the district and their staff here.

Dr. LEE. But they can—let's say there are two types of referrals to Hopkins. One is the physician in the plan deciding a patient needs to be referred for some highly specialized procedure.

Chairman STARK. That physician is on a risk contract and the first \$10,000 comes out of his pocket.

Dr. LEE. Well, there are two things. One is that if the physician chooses to refer the patient, the plan pays for it. And there is in the academic health center fund, the additional funding that would permit that academic health center not to charge the additional costs related to teaching and clinical research.

Chairman STARK. Now, that works and a plan doesn't come down hard on those doctors for referring out, which I suspected—there is no protection to stop them.

Dr. LEE. But the fact is that they are competing on the basis of quality. Now, you mentioned Stanford. Stanford is significantly—

Chairman STARK. They don't compete on quality. You and I know that. People who sign up for the plans, 99 percent of them are healthy. They have no idea what they are getting into. It is only after they get sick that they figure out the plan isn't any good and then they get out. Or they hear about it from their cousin or their brother-in-law or their mother and dad who are in the plan, but people don't sign up for plans. They don't have any idea what the quality is until they get going on it.

They don't take a test appendectomy to see how it feels and then take a test appendectomy at another place. You only go through that drill once.

Dr. LEE. That is part of the reason for the quality report card and the mechanisms to evaluate plan performance.

Chairman STARK. Let me ask you this. Are you willing to evaluate the staff—the faculty at the University of California Hospital and rank on a scale of 60 as failing and 100 is superb, your colleagues in the medical profession and make public your ranking of how you rate them.

Are you willing to do that or do you know any physician who would?

Dr. LEE. Well, plans are doing that now. They are doing profiles on physicians. Kaiser has issued a report card for the public which compares it with other delivery systems, and——

Chairman STARK. That they wrote. That is like——

Mr. LEE. Pardon me?

Chairman STARK. That they wrote. That is like the current administration. Your administration is going to give us a great press release about their plan. I mean, it is going to sound good, I know it.

Dr. LEE. Well, because you look at what that report card said. One of the things it said was that they conducted surveys of their beneficiaries, and one of the problems they found was wait times in the doctor's office. There was a fairly low level of satisfaction with that. They also had, infant mortality. They had surgical mortality, they had other measures, but included was consumer satisfaction. So that would be another mechanism.

The final one to assure this individual option is the point of service option that will be included in each of the plans. In other words, even the group practice and staff model HMOs have to provide in the plan a point of service option.

Chairman STARK. At higher cost.

Dr. LEE. At higher cost, but that would permit the individual to then self-refer.

Chairman STARK. If he could afford it.

Dr. LEE. That is correct. But that choice is there——

Chairman STARK. And if they can afford it, the bottom line is that the institutions are concerned that they will not continue to see the cases that reasonably are referred to them today, and there is a concern. This has been a concern that has been expressed to the committee by these hospitals and doctors, not by me. I couldn't find half of them on a map. So it isn't us that is dreaming this up and it isn't the Republicans who are coming to me with this.

This is Johns Hopkins and Stanford and Mayos and the teaching hospitals are concerned, and you can confuse me, but you have to answer to them, and they are still concerned. And I hope that you can address those concerns, because I don't think they are willing to take the idea that just because suddenly you are turning the Medicaid population over to Humana, that they are not going to have a disproportionate share problem and that it is going to be resolved out of the goodness of the hearts of Humana or Prudential.

I think they think that those may be the problems. I think it was Senator Rockefeller who wanted to characterize Prudential as having a spot in a warmer climate reserved for it, or at least its chief executive officer, and I think that there are others who are beginning to catch on as we get further into this bill.

Dr. LEE. Well, we are working with those academic medical centers. We have met with them on a number of occasions. We are looking to provide this committee and the other committees of the Congress dealing with this issue as much factual information as possible about this issue, about the referral issue, about having those institutions not supporting a maintenance of inefficient oper-

ation, but to assure that the essential functions are maintained in those teaching institutions. And I think one of the reasons that the President's plan puts some of these issues very explicitly on the table is because we are concerned about it.

We think the approaches we have proposed will deal with it, but we certainly want to do everything we can to provide you with the information before you have to make a final decision on this question about whether the amounts of funds are sufficient or whether some of the other policies we have proposed are not adequate.

The whole competitive system, of course, is moving very rapidly in many parts of the country, including California.

Chairman STARK. Did you get a chance to read that Florida thing about the competitive system down there with HMOs that I handed out? I am going to give that to you, make sure you read that carefully. It is one thing to encourage the industry, on the other hand, how do we control this monster after we let it out of the box? Interesting.

Mr. THOMAS. No, I will pass.

Chairman STARK. Thank you. Thank you very much, Phil.

Mr. LEE. Mr. Chairman, just a final point. For the record, I would like to elaborate on my response to Congressman Lewis' question the other day about providers in inner cities, minority physicians and others. We developed a little more detailed response, and I would just like to submit that for the record to really clarify it.

Chairman STARK. If you have a copy, would you give it to Mr. Lewis first and I will have him see that it gets in the record of the hearing on February 2, 1994, relating to managed care.

Mr. LEWIS. Thank you very much.

Chairman STARK. Thank you very much. We are now joined by a panel of experts on the problems associated with providing health care to residents of inner-city and rural communities. Sara Rosenbaum, who is the senior research staff scientist at the Center for Health Policy and Research at the George Washington University; James Bernstein, who is the president-elect of the National Rural Health Association; Larry Gage, who is president of the National Association of Public Hospitals; and John Silva, president of the National Association of Community Health Centers, Inc.

We will suspend for 30 seconds.

Chairman STARK. I thank my distinguished ranking member's indulgence and the indulgence of the witnesses.

Ms. Rosenbaum.

**STATEMENT OF SARA ROSENBAUM, SENIOR STAFF SCIENTIST,
GEORGE WASHINGTON UNIVERSITY, CENTER FOR HEALTH
POLICY RESEARCH**

Ms. ROSENBAUM. Thank you very much for having me here today. I would like to spend my time with you on those issues that underserved, inner-city and rural populations need you to address that go beyond health insurance.

A number of the questions today concerned these issues, which are probably somewhat less familiar on the Ways and Means Committee's work plates than health insurance, where you are the experts.

A couple of things need to be said about underserved urban and rural communities. First all, about three-quarters of all underserved Americans are in inner cities, but three-quarters of the underserved geographic areas of the United States are rural. That is because of the difference in the way underservice is measured.

In rural areas, underservice is more commonly a function of absolute shortage of health care providers. In inner-city areas, underservice is more a reflection of very poor health status measures, particularly with respect to preventable diseases and deaths.

The second point that I think is worth noting is that you have two different problems must be addressed here. The first is the issue of specific underserved populations with very specific, identifiable needs. These populations live everywhere in the United States, in suburbia, in urban and rural areas. Addressing their needs, I think, is a function of the requirements placed on the private health care system that everybody uses in those areas, supplemented by certain kinds of services that go beyond basic medical care.

The second serious problem, which is different to tackle, is what happens when many underserved people live in concentrated areas. That is the problem that brings remote rural areas and inner-city areas very close together. The people may be further apart, but the bottom line is the same. There are too many poor people with too many health problems comprising too big a percentage of the service area.

In the testimony that I submitted, I tried to give you a sense of how much health care spending happens today and is going to continue to happen on an out-of-pocket basis. Even under a broad health insurance reform bill, people need money to buy health care and related services. Poor communities, whether urban or rural, do not have the financial wherewithal to support a health care infrastructure.

Only a portion of health care spending goes into health insurance, and therefore to build a health care system in very, very underserved areas requires public investment beyond insurance. These investments also should be financed on a mandatory basis.

The one bill that does that right now is the bill sponsored by Representative McDermott and Senator Wellstone. That bill builds funding for these services directly into what essentially is the health insurance premium payment.

I think that this approach represents a very equitable way to do it because the cost of underservice is a cost that society has brought on itself through decades of discrimination and segregation. The cost of building services through facilities development, through health professions training programs, through enabling services and other kinds of services mentioned in my testimony and that of my colleagues is something that is a social obligation, just as insuring people is.

So I urge you to look at the Wellstone-McDermott bill as a model for tackling the problem of how to finance this care. Beyond the issue of the financing is the issue of the civil rights requirements and the regulatory requirements that you choose to impose on health plans.

We face two kinds of problems, one being no services at all and the other being a deluge of underservice by health plans. We are not going to correct the later problem without clear, measurable standards on the performance of health plans. Health plans under civil rights laws have escaped regulation and have done so because there is no recognition of poverty as a civil rights issue. That is the place where the performance standards you impose will have a lot to do in how they reach underserved populations.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

**TESTIMONY OF SARA ROSENBAUM,
GEORGE WASHINGTON UNIVERSITY**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to appear before you today to testify on inner city and rural populations and national health reform. How these populations fare in health reform should be viewed as a matter of extreme importance because the health needs of inner city and rural residents are so urgent and because there are substantial economic and social consequences if national reform fails to effectively address these needs. This testimony examines the special issues that inner city and rural populations present in health reform and the policy reforms that should be included in order to make health reform effective for them.

1. What special issues do inner city and rural populations present in health reform?

In reviewing the special health reform issues presented by inner city and rural populations, two separate matters must be considered. First, policy makers must identify various types of urban and rural populations who can be considered vulnerable because of their special health needs or the conditions under which they live, or both. The second is to consider the additional problems that are created (and the additional solutions that are required) when the concentration of vulnerable individuals is so great that an entire urban or rural community can itself be considered "vulnerable".

The overall numbers: Over 43 million persons can be classified as medically underserved.¹ Underserved persons span all ages and live everywhere but are most heavily concentrated in inner city and rural areas. Seventy percent of all U.S. counties can be classified as wholly or partially medically underserved based on their depressed health statistics, the shortage of health care providers or both.² Of the more than 43 million underserved persons, 14.2 million are under age 18, 5.7 million are under age 5, and 9.1 million are women of childbearing age.

The populations in question: The causes of medical underservice extend beyond the absence of health insurance. Persons at risk for medical underservice include:

- ▶ **Insured low income persons:** 60 percent of all medically underserved Americans have some form of health coverage.³
- ▶ **Residents of inner cities:** More than 78 percent of all medically underserved persons are residents of metropolitan areas; within MSAs, the underserved tend to be concentrated in central city areas. In the case of the urban poor, underservice is more frequently a function of depressed health status measures. This indicates a lack of accessible primary health care services.
- ▶ **Residents of rural areas:** While rural residents comprise only slightly more than 21 percent of all medically underserved persons, rural counties constitute 74 percent of all medically underserved counties. Among rural populations, absolute provider shortages are a more common cause of medical underservice.
- ▶ **Members of racial and ethnic minority groups:** Racial and ethnic minority populations comprise a disproportionate percentage of the medically underserved. This disproportionate level of underservice among minority Americans can be seen in the disproportionate reliance on publicly funded health clinics by members of minority groups.
- ▶ **Homeless persons:** An estimated 2 million persons are homeless. Approximately one-third are believed to have an alcohol or substance abuse problem while 25 percent have a mental illness.

¹ Daniel Hawkins and Sara Rosenbaum, Lives in the Balance National Association of Community Health Centers, Washington, D.C. 1993 (1993).

² Hawkins and Rosenbaum, op. cit

³ Ibid.

- ▶ **Migrant farmworkers and their families:** Over 4 million migrant farmworkers and their families travel throughout rural areas of the nation each year. Their mobility makes effective health coverage particularly difficult, and their health risks are especially great.
- ▶ **Persons with HIV and other communicable diseases:** Persons with or at risk for communicable disease are at particularly high need of comprehensive health services. But persons with high health risks are found in especially concentrated numbers in underserved communities. While 70 percent of all U.S. counties are medically underserved, underserved urban and rural counties account for 90 percent of the nation's hepatitis cases, 93 percent of all cases of tuberculosis, and virtually all cases of vaccine preventable disease.⁴
- ▶ **Persons with serious physical, developmental and mental illness, disorders and disabilities:** Persons with serious physical, developmental and mental health problems live in all communities. But medically underserved urban and rural communities account for a disproportionate percentage of health conditions such as infant low birthweight which are associated with certain types of lifelong disabilities such as retardation, cerebral palsy, and developmental disabilities.
- ▶ **Persons who speak limited or no English:** Medically underserved persons disproportionately speak limited or no English. Seventeen percent of all rural health center patients and 13 percent of all urban patients speak limited or no English.
- ▶ **Persons who are undocumented:** Estimates of undocumented persons living in the U.S. range from a low of about 3 million to a high of more than 10 million. Undocumented persons are among the most vulnerable of all persons at risk because of the deep impoverishment and substandard conditions under which they live. They disproportionately are concentrated in central city and rural communities.

While many factors related to geography and personal characteristics can make populations vulnerable to underservice, the common thread is poverty. Underserved inner city and rural populations are disproportionately poor. Poverty has major consequences for both health status and access to health care, and the greater poverty of inner city and rural communities must be taken into account in fashioning health reform.

Access barriers faced by underserved populations: Universal health insurance coverage represents the critical first step in assuring access to health care for all Americans. But the causes of medical underservice are complex, and studies indicate that underservice exists even in the face of reasonably adequate health coverage. Even when insured, vulnerable individuals receive less primary health care and less specialized care. The race and ethnicity of patients has a measurable, and limiting, effect on the amount of health care they receive, and the settings in which they receive it, even when other factors are controlled for.⁵

In fashioning a health reform plan that works for underserved inner city and rural

⁴ Hawkins and Rosenbaum, op. cit.

⁵ Numerous studies indicate racial and ethnic health care utilization disparities in care. David Kindig, et al. "Physician Supply in Rural Areas with Large Minority Populations" *Health Affairs* (Summer 1993) p.177-184; Alan Gittelsohn, et al. "Income, Race and Surgery in Maryland" *American Journal of Public Health* Nov. 1991, Vol. 81, No. 11, p. 1435-1441; Rodney Hayward, et al. "Inequities in Health Services among Insured Americans" *The New England Journal of Medicine* Vol. 318, No. 23, p. 1507-1512; Sandra Blakeslee "Studies Find Unequal Access to Kidney Transplants" *The New York Times* Jan. 24, 1989; Robert Blendon, et al. "Access to Medical Care for Black and White Americans" *JAMA* Jan. 13, 1989, Vol. 261, No. 2, p. 278-281; Mark Wenneker and Arnold Epstein "Racial Inequalities in the Use of Procedures for Patients with Ischemic Heart Disease in Massachusetts" *JAMA* Jan. 13, 1989, Vol. 261, No. 2; Kenneth Goldberg, et al. "Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery Rates for all 1986 Medicare Patients" *JAMA* March 18, 1992, Vol. 267, No. 11, Jonathan Javitt, et al. "Undertreatment of Glaucoma among Black Americans" *The New England Journal of Medicine* Nov. 14, 1991, P. 1418-1422; Bertram Kasiske, et al. "The Effect of Race on Access and Outcome in Transplantation" *The New England Journal of Medicine* Jan. 31, 1991, p. 302-307; Alfred Summer, et al. "Racial Differences in the Cause-Specific Prevalence of Blindness in East Baltimore" *The New England Journal of Medicine* Nov. 14, 1991, p. 1412-1417; Suezanne Orr, et al. "Differences in Use of Health Services by Children According to Race" *Medical Care* September 1984, Vol. 22, No. 9, p. 848-853.

Americans, Congress must consider two separate types of situations. The first involves communities in which vulnerable individuals are dispersed in relatively small numbers throughout the general population. Adaptation of existing health care financing and service delivery arrangements accompanied by the development of certain types of supplemental services, may prove quite effective in communities with relatively small numbers of vulnerable persons; furthermore, the potentially higher cost of treating such persons can be spread throughout the community.

But decades of residential segregation and deep poverty have led to the concentration of large numbers of especially vulnerable persons inner city communities fraught with high health risks. Similarly, many rural communities face deep impoverishment, not merely pockets of poverty. In urban and rural communities comprised largely of low income and vulnerable populations the health reform challenges grow, because as a whole, these communities simply are too poor and high risk to attract and sustain a decent and functioning health care system without additional direct aid. Health care financing interventions must be broader than health insurance alone if the overall community ecology is to be able to support a viable health care system.

The limits of health insurance as a health care financing tool for vulnerable persons and communities: Many people believe that health insurance coverage alone can achieve a redistribution of health resources by improving the market purchasing providers of low income persons and communities. In areas of the country in which the poor are widely dispersed, there are clear signs that insurance coverage has a measurable and positive effect on "mainstreaming."⁶

But in urban and rural communities with high concentrations of low income, vulnerable and underserved persons, health insurance alone is not the only necessary solution. Many factors such as the race and personal characteristics of patients⁷ and the quality of the practice environment affect practitioner location. As important may be the fact that the overall economic environment of underserved communities is too weak to support health care systems even with improvements in health insurance coverage.

In a country that depends on private health insurance to finance a sizable proportion of medical care, extending coverage is the obvious first step toward assuring financial access to health services. But health insurance is only one of the ways that Americans pay for health care. In addition to health insurance, the nation relies heavily on out-of-pocket spending to pay medical bills; it is this out-of-pocket spending capability that is virtually missing in poor and near-poor communities.

According to the Health Care Financing Administration, in 1991 out-of-pocket payments amounted to \$144 billion, 22 percent of all spending for personal health services. Out-of-pocket spending was highest for ambulatory care and services, as shown on Table 1.

⁶ James Fossett, John Peterson, Mary Ring, "Public Sector Primary Care and Medicaid: Trading Accessibility for Mainstreaming," *Journal of Health Politics, Policy and Law*, 14:2 (Summer 1989) pp. 309-325.

⁷ David Kindig and Guo Yan, "Physician Supply in Rural Areas with Large Minority Populations" *Health Affairs* (Summer, 1993) pp. 178-184.

Table 1
Out-of-Pocket Spending* as a Proportion of Total Personal Health Spending

Service	Proportion Paid Out-of-Pocket
All personal health services	22%
Hospital care	3%
Physician services	18%
Dental services	54%
Drugs and other non-durables	73%
Vision products and other medical non-durables	62%

* Excludes premiums

Source: Letsch, Lazenby, Levit and Cowan, Health Care Financing Review 14:2 (Winter, 1992)

Out-of-pocket health expenditures cover a variety of things, including uncovered health services (for both medically necessary and purely elective care), deductibles, and coinsurance. It does not include items and services essential to good health such as food, shelter and other health-related services.

In setting insurance premium rates, actuaries assume the availability of out-of-pocket expenditures. These assumptions are reflected in overt limits on coverage (such as psychiatric visit limits) as well as in deductibles, coinsurance, and annual and lifetime maximum coverage limits. Moreover, out-of-pocket expenditures are covertly built into health coverage schemes as well, through administrative techniques such as appointment scheduling delays or long waits for prior approval that are designed to discourage the use of insured services and encourage out-of-plan service utilization.⁸

Given the limits of health insurance as a health care financing mechanism, health providers derive a sizable proportion of their annual revenues from out-of-pocket payments. Furthermore, it is probably safe to assume that whatever health reform plan finally emerges will continue to depend on sizable out-of-pocket spending by insured persons, simply because the plan will not be financed in a manner that avoids the need for supplemental personal spending on medical and health related services.

Constrained premium rates, dependence on out-of-pocket payments for uncovered health services, the desire to avoid high medical risks will mean that many health plans will continue to avoid communities with high concentrations of poor persons. These communities also will remain at a major disadvantage in attracting and retaining sufficient numbers of primary and specialized health care providers. Even with health insurance, poor communities as a whole are incapable of making the types of out-of-pocket medical and health-related expenditures on which a privately financed health system depends.

Over time, poor broader insurance coverage and an increased emphasis on primary health care training may have a redistributive effect on health care providers. But this evolution will be slow in coming, given the overall shortage of primary health care providers (the shortage of primary care physicians is estimated to stand at between 50,000 and 70,000) and the plentiful opportunities to practice in more affluent communities. Even if health insurance payment rates are increased to compensate for the lack of out-of-pocket spending,

⁸ Milton Roemer and William Shonik (1973) "HMO Performance: The Recent Evidence" Milbank Memorial Quarterly pp. 271-317 (Summer).

the continued presence of uninsured, sporadically insured, and underinsured persons (such as undocumented persons, migrant farm workers and homeless persons) will detract providers.

At the same time that many poor communities may continue to experience a shortage of health personnel, other poor communities may experience "mirror-image" type of problem: the movement into the community of underfinanced prepaid health plans that depend on an excessive reduction in health care service utilization to show a profit. There is already ample evidence from the past and recent history of managed care under the Medicaid program of the impact of under-financed managed care on vulnerable patients and communities.⁹ Indeed, some health plan executives report that, far from representing a loss, Medicaid managed care may yield high profits (at least in the short term) because the poor are such low users of care and are easily deterred from seeking services.

Thus, even with health insurance reform, the urban and rural poor remain vulnerable to two basic health care access problems. The first is a complete lack of services in communities that cannot afford to attract and maintain health care providers of good quality. The second is the burgeoning number of underfinanced prepaid health plans that require providers (however fragile) to organize into prepaid networks that place far too high a level of financial risk on individual practitioners and institutions, and that ultimately are forced to depend on systemic under-service for economic survival.

2. What do vulnerable urban and rural populations need in health reform?

Over the past 25 years, countless studies have analyzed what makes a health system -- both health insurance and health care services -- responsive to the needs of vulnerable populations and communities. From these studies, three basic points emerge. First, responsive health systems take special steps to make insurance coverage itself accessible, affordable and of good quality. Second, responsive systems ensure that health care providers serving vulnerable populations have access to additional direct financing in the form of capital development and operational support. These added direct supports are provided in recognition of the fact that health insurance alone does not offer providers for the underserved a sufficiently adequate financial base. Third, a responsive system emphasizes provider practice adaptations to fit the health needs of their patients. Adaptation examples include location, hours, languages spoken, the mix of health and social services offered, and other community-responsive services.

a. Making insurance affordable, accessible and of good quality: To be appropriate for vulnerable populations insurance reforms should include the following provisions:

- Premiums must be kept nominal: Poor patients cannot afford premiums, and near-poor patients should bear premium burdens that are in keeping with their limited ability to pay health care costs (3 percent of annual income or lower).
- Cost sharing must be nominal: A large number of studies underscore that premiums that exceed nominal amounts limit access to necessary health care, particularly in the case of preventive and primary health care.
- Benefits should adequate: Benefits should be broad enough to cover primary and acute care needs as well as services for persons with chronic illness and disability.
- Enrollment must be simple and accessible: Enrollment sites should be located throughout a community and available in the evenings and on weekends. Enrollment assistance should be made available for persons with limited English-speaking ability and for persons with special needs for assistance in enrolling in a health plan.

⁹ See studies by GAO and others cited in Medicaid and Managed Care: A Literature Review (Forthcoming, Kaiser Commission on the Future of Medicaid, Washington, D.C., 1994).

- Special provisions must be made for transient worker populations: Special provisions should be included for persons who travel for work, such as migrant farmworkers. In a state-based health reform system in which coverage depends on state residency, special reciprocal arrangements are needed to ensure that migrants' coverage is honored by providers in all states and that families are not required to reapply each time they enter a new state. Fee-for-service or point-of-service plans are of particular importance so that families are not limited in their use of insured out-of-area, medically necessary services during travel periods.
- Fee-for-service or point-of-service plans should be financially available to all persons regardless of income. Lower income families tend to have far less stable living arrangements and may move frequently. Closed-network provider plans are particularly unsuitable for these families, who may frequently find themselves out of the plan's service area. This is true in both inner city areas, where 30 city blocks may place a family "out-of-area", as well as rural communities where distances are great.

b. Direct financing for the development and support of health providers in underserved areas:

In communities with high concentrations of low income and vulnerable populations, a resource development strategy is absolutely essential. Without a systematic strategy, these communities will be unable to attract or sustain health services of adequate quality. Elements of a provider development and support strategy include:

- Funds to develop primary health care services: Service development needs include funds to plan the development of new service sites and networks, and funds to acquire or refurbish facilities, purchase equipment, recruit and train medical, clinical and administrative staff, set up billing and management and information systems, and assume other costs associated with establishing a comprehensive medical practice.
- Funds to establish risk reserves in the case of health providers participating in risk based plans.
- Special reinsurance and stop-loss arrangements to cushion providers against the higher level of risk incurred in providing health care to sicker patients: Steps must be taken to limit the financial risks incurred by providers working in underserved areas, with special consideration given to primary health care services. This can be done through special payment rates for providers practicing in underserved areas or special stop-loss rules designed to lower the financial risk of furnishing more intensive levels of primary health care. The Federally Qualified Health Centers and Rural Health Clinic Service programs created by this Committee both are excellent examples of special payment arrangements. Emerging data suggest that these payments have not only helped sustain provider practices in underserved urban and rural communities but have also aided in their growth and expansion.

It is important to emphasize that risk adjusted payments to health plans alone are not enough. Additional payments to health plans will have little impact on the stability of individual providers or availability of primary health services if the plans do not adjust the level of financial risk borne by the providers. The history of prepayment under Medicaid reveals numerous instances in which plans whose risk capitation payments may have been reasonably adequate to begin with nonetheless failed to appropriately control the level of financial risk passed on to individual health providers and left communities at risk for underfinanced primary health services.

- Grants to pay for health related and social services not covered by insurance: Health providers in underserved communities must be able to furnish more than traditional medical care if their services are to be appropriate, community-responsive, and effective. Of particular importance are case management, translation,

transportation, social work, outreach and social support services. None of these services are financed by traditional forms of private insurance. Providers who offer these services today normally do so through operating grants.

- Funds to cover the cost of uninsured and underinsured patients: In the event that health reform excludes insurance coverage for undocumented persons, health reform should provide for the direct support of health services. Funding is needed both for the overall health and safety of these individuals and the communities in which they reside and to avoid the continued need to shift the cost of care and services onto other payers. An adequately financed successor program to the existing Medicare and Medicaid disproportionate share program will be needed. Similarly, support is needed to cover unpaid deductibles and coinsurance, uncovered but necessary health care and services for persons with chronic illness and disability care for persons who temporarily lose their coverage, and services for patients who are unable to obtain the care they need from providers affiliated with their health plan networks.
- Rules to ensure that health plans allow full participation by providers to underserved populations and do not use exclusionary practices to limit their own financial risk exposure. This means minimum guaranteed contracting requirements on terms and conditions at least equal to those extended to other providers.

c. Adaptation of health services to the needs of underserved and vulnerable populations and communities:

In addition to supporting health providers that traditionally have served inner city and rural populations, health reform legislation should include provisions to measure the appropriateness and quality of health care to all patients. Health outcomes indicators are important but not sufficient by themselves. At a minimum, data must be collected by race, ethnicity and socio-economic status to assure that variations in health outcomes for vulnerable sub-populations are detectable from the norm.

Process-of-care criteria also must be developed to assure that health plans and providers furnish services that do not readily lend themselves to immediate health outcomes measures but that are nonetheless essential to the overall health and well-being of patients. Examples are night-time and weekend hours, location of services, language accessibility, linkages to special community health programs, health education, and other services.

Finally, a critical quality of care measure for vulnerable populations and communities is the community orientation of health plans and participating providers. Examples of community orientation include services such as assistance in enrolling in SSI, WIC, job training and social service programs, offering on-site patient support and community service programs, offering services located off-site and at accessible locations such as schools and community centers, participation in the development of special education services plans for children with educational disabilities, and other community-oriented practices.

This nation has a long history of developing and supporting community-oriented health programs with federal, state and local funding. Examples can be found in the programs created under the Public Health Service Act and in the special community based ambulatory care and inpatient programs and providers developed and supported with state and local funding. The nation's health budget should include a base of funding for the maintenance and growth of these programs. In addition, the community-oriented practice arrangements which many of these programs have pioneered should be preserved and replicated -- not diminished -- by health reform. The practice modes which these providers have developed should be supported financially, and their essential elements incorporated into quality of care measures applicable to all health plans in all communities.

Chairman STARK. Mr. Bernstein.

**STATEMENT OF JAMES D. BERNSTEIN, PRESIDENT-ELECT,
NATIONAL RURAL HEALTH ASSOCIATION, AND DIRECTOR,
NORTH CAROLINA OFFICE OF RURAL HEALTH**

Mr. BERNSTEIN. I am representing the National Rural Health Association, whose membership is comprised of small rural hospitals, community and migrant health centers, rural health clinics, primary care physicians, nonphysician providers, educators and other concerned rural citizens.

NRHA urges serious consideration and passage of a health reform plan that ensures universal access to health care for all populations. NRHA distinguishes universal access to basic comprehensive primary health care services. In our estimation, providing a health care card and offering health care benefits does not go far enough to providing quality primary health care services.

American citizens, particularly those in isolated rural and frontier communities, must have access to primary health care providers as a way to enter the health care system.

NRHA urges serious consideration and passage of a health reform plan that ensures universal access to health care for all populations. Three intertwined components of health reform are of a special concern for us.

First is the work force issue. Unless this issue is addressed in a multifaceted way—I truly believe not only will rural communities not be able to replace existing providers, but many of them will move to urban and suburban communities.

A managed competition reform strategy will create a feeding frenzy for primary care providers, the likes of which I do not believe any of us can predict. If we do not prepare carefully and comprehensively for this foreseeable outcome, rural Americans could find themselves seriously disenfranchised from the health care system.

Therefore, we recommend significantly increasing funding for the programs that train primary care providers and encourage ambulatory training in rural communities. For an off-campus program to be successful, the physicians doing this training need to be reimbursed for their time. Not only will this make for a larger and better strategy, but it is fair.

Other innovative incentives, both carrots and sticks, need to be explored for professional schools and students to encourage rural primary care practice.

The second concern for us has to do with how reform will be financed. Rural health providers of Medicare part A and part B health services feel extremely threatened by the administration's proposal to finance part of health reform from cuts in the Medicare program.

Rural America not only has a higher proportion of elderly citizens, but most rural providers are dependent on Medicare reimbursements.

Another financing concern relates to services for primary care. I never did understand how one reconciled the two policies—one of reimbursing rural providers less than urban providers; and two a

policy to encourage primary care providers to practice in rural and other urban underserved communities.

If we want to recruit and retain primary care physicians to rural and inner-city areas, we probably will need to consider reimbursement at higher rates than the rest of the country. As far as essential community providers are concerned, we will always need them to serve certain parts of rural America.

The third major concern focuses on community-based health systems development strategies. With all the talk about managed competition and integrated systems development, especially by the large insurance companies, HMOs, and tertiary care hospitals, we tend to forget who is providing care in rural America today—local private MDs, small hospitals, health departments, and other community-based organizations like community health centers and rural health clinics.

We believe a successful health reform strategy will recognize this fact and attempt to build on the strengths of a community-based system combining them appropriately with integrated systems development.

It is important to remember these big HMOs and hospitals, including teaching centers, have had relatively little success and interest in rural America over the past 25 years.

The membership of the National Rural Health Association appreciates this opportunity to provide you with input to the national reform development process.

I would like to conclude by saying I am very concerned about the attack last week by various groups on what I believe are the very basic tenets of health reform and urge you not to compromise universal access.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

**STATEMENT OF THE NATIONAL RURAL HEALTH ASSOCIATION TO THE HOUSE
WAYS AND MEANS COMMITTEE, SUBCOMMITTEE ON HEALTH, PRESENTED BY
JAMES D. BERNSTEIN, PRESIDENT-ELECT, FEBRUARY 7, 1994**

Chairman Stark and Members of the Ways and Means Subcommittee on Health. My name is James Bernstein, President-elect of the National Rural Health Association and Director of the North Carolina Office of Rural Health. I am representing the National Rural Health Association whose membership is comprised of small, rural hospitals, community and migrant health centers, rural health clinics, primary care physicians, non-physician providers, educators and other rural health advocates.

The National Rural Health Association appreciates the opportunity to testify on the implications of national health reform on rural communities.

The National Rural Health Association urges serious consideration and passage of a health reform plan that ensures universal access to health care for all populations. NRHA distinguishes universal access from universal coverage by defining universal access as access to basic comprehensive primary health care services. In our estimation, providing a health care card and offering health care benefits does not go far enough to providing quality health care services. American citizens, particularly those in isolated rural and frontier communities must have access to primary health care providers.

NRHA must insist that universal access includes the following elements:

- (1) Health Systems Work Force
- (2) Health Systems Financing
- (3) Community-Based Health Systems Development.

HEALTH SYSTEMS WORK FORCE CONSIDERATIONS

Any national health plan should provide policy direction and funding for the education and training of a sufficient number and mix of appropriate health care providers to meet the personnel needs that exist throughout rural America. Our specific recommendations include but are not limited to:

- * Significantly expand programs and increase funding for health care personnel training programs, scholarships and other subsidization and innovative programs to prepare and retain providers.

- * Adopt financing programs that encourage ambulatory training experiences in rural areas and create incentives for training programs and rural delivery sites, including payments to providers in these settings who teach.

HEALTH SYSTEMS FINANCING ISSUES

There are two major issues in financing health systems reform that must be considered in implementing national health reform. These are: (1) how to finance the overall system and (2) how to pay for services as well as reimbursement focusing on the patient/provider relationship.

NRHA recommends that reform of the health system cannot take place by reducing Medicare. Rural areas, with their disproportionate number of elderly, will suffer inordinately with any decrease in Medicare funding.

COMMUNITY-BASED HEALTH SYSTEMS DEVELOPMENT STRATEGIES

A major element of health care reform is the restructuring of the health care delivery systems. It is critical to rural citizens that there be access to at least basic health care services and ideally to a set of choices of comprehensive community-based health care services.

It is equally as critical that there be a mechanism that recognizes and maintains the contributions of essential community providers -- those community-based providers who have established themselves and demonstrated their ability to provide access for residents of rural underserved areas. There must be assurances that essential community providers participate and be protected in payment

agreements during the initial five year transition. Moreover, it is imperative that the underserved residents that essential community providers serve be given assurances that they will always have access to comprehensive primary care services.

NRHA supports the development of strategies to retain rural community-based health care services, and incentives to encourage the development of stable systems of care that combine community development principles with integrated systems development.

MEDICARE FINANCING/MEDICARE SAVINGS

The President's plan to achieve \$124 billion in savings over five years by reducing the rate of growth in Medicare spending would have the greatest impact on the rural elderly. Reflecting a population that is disproportionately older and poorer, rural providers are more dependent on Medicare and Medicaid programs. Thirteen percent of rural residents are 65 years of age or older compared to 10.7 percent of urban residents.

Most rural hospitals under 49 beds receive over 50 percent to 70 percent of their net income from acute Medicare patients and in excess of 66 percent of their patient days being Medicare. Statistically, HCFA reports much less than this, but they include referral centers and larger rural hospitals adjacent to urban facilities.

In 1992, the Prospective Payment Assessment Commission (ProPAC) reported that nearly 28 percent of all rural hospitals had negative total operating margins, while 39 percent of rural hospitals of less than 50 beds had negative total margins.

In the State of North Carolina, there are 126 PPS hospitals. 77 hospitals or 61 percent are rural. Medicare reimbursement represents 47 percent of the revenue to all North Carolina hospitals. Medicare payments represent 54 percent of the income for rural hospitals versus 40 percent for the urban.

In 1991, the overall operating margin was 6 percent for all hospitals. For rural hospitals, the overall operating margin was 5 percent. However, PPS margins on average for rural hospitals were a negative 10 percent. Of the 77 rural hospitals, 12 hospitals or 16 percent of the rural hospitals had negative operating margins. We anticipate that upon review of the 1992 data, we will see a trend toward higher negative PPS operating margins for rural hospitals.

Preliminary estimates by the North Carolina Hospital Association anticipate that reductions in Medicare payments would total \$1.9 billion for the period of 1995-2000.

With the implementation of Medicare Prospective Payment System, (PPS), rural hospitals reduced inpatient capacity and increased capacity for outpatient services. Now, rural hospitals receive more than 50 percent of their Medicare reimbursement from outpatient services.

The loss of rural Medicare Geographic reclassification status, coupled with the Medicare cuts imposed by OBRA 1993, (particularly the reductions in capital and outpatient spending), will only exacerbate the problem of access for rural citizens to viable rural providers.

Rural health care providers are only seeking assistance in leveling the playing field in access to capital. The definition of capital projects must be broadened. National health reform will require capital infrastructure development of community-based health care institutions. It will require expenditures for bricks and mortar, as well as systems transitions and acquisitions.

The National Rural Health Association recommends continuing Medicaid disproportionate share hospital payments to those hospitals serving a disproportionate share of low-income patients during the five year transition period.

We also recommend not eliminating the Medicare adjustment for outpatient capital costs for rural and inner city health care facilities.

Further, we recommend increasing access to capital, including projects of less than \$300,000 for facility improvement or development of rural community-based health care facilities.

Moreover, we recommend that accessible and affordable funding should be available to rural institutions to fund planning and construction costs of converting existing facilities to other models when appropriate.

REIMBURSEMENT RATES BASED ON HISTORICAL COSTS

The National Rural Health Association recommends that historical costs not be used to determine the level of reimbursement for rural providers. Rural providers have, over the past two decades, suffered inequitable federal reimbursement. Particularly since the implementation of the Medicare Prospective Payment System, rural hospitals were placed at a distinct disadvantage to urban hospitals. Despite the fact that rural hospitals pay the same or higher prices for drugs and other supplies and the same or higher salaries for medical personnel, Medicare has, over the years, reimbursed rural facilities at rates up to 40 percent less than urban hospitals.

Biases exist in the historical payment to rural primary care providers. The Medicare reimbursement for office visits are substantially lower than the cost of providing the services. Medicare fees simply do not begin to cover the time and material that it takes to serve rural elderly residents.

The experiences of rural health clinics best illustrates the inherent biases in historical payments to rural providers. Rural health clinic reimbursement has been artificially suppressed as a result of the placement of caps that were not increased for many years. Any future payments based on historical experience will continue to place rural providers in an untenable financial position.

The National Rural Health Association recommends that practice expense payments for primary care services should be increased as advocated by the American Academy of Family Physicians.

HEALTH SYSTEMS WORKFORCE

Increases in incentives for primary care providing training for all disciplines is critical to rural areas. It is the hope of the rural constituency that greater emphasis on quality training at rural ambulatory, hospital and non-hospital sites will become a recruitment point for luring primary care physicians and non-physician providers to practice in rural communities.

NRHA supports direct graduate medical education reimbursement to rural ambulatory, hospital and non-hospital sites and paying of local providers for their time to teach.

The National Rural Health Association promotes a policy which adequately redirects graduate medical education payments to achieve a goal after a five year phase-in period of at least 50 percent of new physicians being trained in primary care rather than in specific specialty fields in which an excess supply currently exists.

Mr. Chairman, the National Rural Health Association is committed to working with the Congress and the President to ensure universal access through a national health reform plan this year.

Chairman STARK. Now Larry Gage is going to tell us that all these big-managed care providers and HMOs are just gobbling up more patients in the inner city which is why they don't have time to come out and see you in the rural communities.

**STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL
ASSOCIATION OF PUBLIC HOSPITALS**

Mr. GAGE. I may tell you that later. We know they are gobbling up premiums. We are not sure they are gobbling up patients.

I am Larry Gage, president of the National Association of Public Hospitals. NAPH has just 100 members, but these hospitals and health systems have combined budgets of over \$16 billion and they provide 71 percent of their services to Medicaid and other low-income patients. I might add that in addition to systems like Alameda and Santa Clara County and Grady Memorial Hospital in Atlanta, we have rural systems like San Bernardino County, Kern County and Riverside County in California.

The point I wanted to make to augment some of the things said today is that it is essential that you understand as you debate health reform that the importance of these hospitals and health systems extends services they provide to their entire communities and not just to the poor. For example, they often serve as the only provider of many costly specialized medical and public health services such as trauma care, burn neonatal intensive care et cetera.

By way of example, let me refer to news stories that graphically illustrate this community-wide mission. I have some visual aids here. One of these dated Tuesday, January 18 was headlined, "A Tidal Wave of the Walking Wounded."

It refers to the extraordinary services provided to thousands of California earthquake victims by the hospitals of the Los Angeles County health system, generally, and in this case, the county's Olive View Medical Center in particular. You can see row after row of emergency patients who being treated in the hospital parking lot.

The second article dated January 7 headlined, "Girl Beats Odds After Devastating Ski Run Accident," describes Brooke Sebold who was a 12-year-old girl, the daughter of a Texas physician. Brooke was brought by air ambulance from Vale, Colo. to the State's only level 1 trauma center at Denver General Hospital with a severely lacerated liver, multiple injuries and a less than 5 percent chance of survival.

Two weeks later, she walked out of Denver General after a remarkable team of 20 physicians and a brandnew trauma center saved her life.

The point of these examples is that even if health insurance is available to pay for the specific care provided to Brooke Sebold and many California earthquake victims, health insurance alone will never adequately pay the substantial standby costs of these essential systems and services.

These services are available only because they are currently supported by a fragile web of funding sources, including local taxpayer subsidies, Medicare and Medicaid disproportionate share and teaching adjustments, and a very limited amount of private sector cost shifting.

These stories are not isolated or unique. In just the last year or two, we have seen many other examples of the need to preserve such essential standby services, from Hurricane Andrew to the Midwest floods to the World Trade Center bombing to the Los Angeles riots, to the recent measles epidemic in Milwaukee in which two-thirds of the hundreds of unimmunized children hospitalized were already members of Medicaid-managed care plans.

NAPH member hospitals have for many years served as the most essential providers in their respective urban communities, playing this role despite many fiscal and administrative obstacles which are documented in detail in my prepared testimony.

We are concerned also about the statements made by a number of organizations last week and by the increasing polarization of the debate. For this reason, in conclusion, NAPH decided 2 weeks ago to endorse the major principles and key provisions of President Clinton's Health Security Act.

It is not that we believe that the President's proposed bill is perfect or that it cannot be improved. Indeed we are concerned that the untested concept of managed competition cannot in the foreseeable future meet all of the health and social needs of low-income residents of our Nation's inner cities.

We are also concerned about the funding levels and continuation of many of the programs that you were discussing with Dr. Lee earlier today. However, we are convinced that the Health Security Act offers you a excellent and realistic foundation upon which to build a comprehensive universal mandatory health plan.

We are unanimously committed to working with the President and the members of this committee to achieve enactment of universal mandatory health coverage as swiftly as possible.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

**Statement of Larry S. Gage
President**

National Association of Public Hospitals

before the

**Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington D.C.
February 7, 1994**

Mr. Chairman, Members of the Subcommittee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). I am pleased to have this opportunity to testify before the Subcommittee on the importance of universal, mandatory national health reform to America's urban health safety net hospitals and health systems.

NAPH's members include over 100 of those safety net institutions. With combined revenues of almost \$16 billion, they provide over 71% of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as "national health insurance" by default in most of our nation's urban areas. At the same time, they train a substantial proportion of our nation's doctors, nurses, and other health professionals.

As you begin to deliberate health reform, it is essential that you understand that the importance of urban safety net hospitals and health systems also extends to the services they provide to their entire communities, not just the poor. For example, they often serve as the only provider of many costly, specialized medical and public health services, such as trauma care, burn care, neo-natal intensive care, high risk pregnancy services, and emergency psychiatric care. By way of example, let me refer you to two recent news stories that graphically illustrate this essential community-wide mission.

One of these, dated Tuesday, January 18, 1994, was headlined "A Tidal Wave of the Walking Wounded", refers to the extraordinary services provided to thousands of California earthquake victims by the hospitals of the Los Angeles County health system generally, and the County's Olive View Medical Center in particular. A photograph accompanying the article shows trauma physicians treating row after row of emergency patients spread out across the hospital's parking lot.

The second article, dated January 7, is headlined "Girl Beats Odds After Devastating Ski Accident". It describes Brooke Sebold, a 12 year old girl, the daughter of a Texas physician, who was brought by air ambulance from Vail, Colorado to the state's only Level I trauma center at Denver General Hospital, with severely lacerated liver, other multiple injuries, and a less than 5% chance of survival. Two weeks later, Brooke walked out of Denver General, after a remarkable team of 20 physicians saved her life.

The point of each of these cases is that even if health insurance is available to pay for the specific care provided to Brooke Sebold and many of the earthquake victims, we believe it is highly unlikely that the President's plan -- or any of the other reforms being proposed -- will adequately pay the substantial standby costs of making sure the essential systems and services are going to be available when they are needed. These services are available only because they are currently supported by a fragile web of funding sources, including local taxpayer subsidies, Medicare and Medicaid disproportionate share and teaching adjustments,

and a very limited amount of private sector cost shifting. And these cases are not isolated or unique. In just the last year or two we have seen many other examples of the need to preserve such standby services, from Hurricane Andrew to the Midwest floods to the World Trade Center bombing to the Los Angeles riots to the recent measles epidemic in Milwaukee, in which over two thirds of the hundreds of unimmunized children hospitalized were already members of Medicaid managed care plans.

NAPH member hospitals have for many years served as the most "essential" providers in their respective urban communities, playing this role despite facing many fiscal and administrative obstacles. The situation of many of these urban safety net hospitals continues to worsen today, even as the significance of their community wide services continue to be emphasized by recent events. The nation's urban public hospitals continue to be burdened by multiple crises -- including persistent state and local budget shortfalls -- escalating federal and state curbs on Medicaid eligibility and spending -- continuing increases in the number of uninsured and under-insured -- and an increasing inability or unwillingness of many providers to shift uncompensated costs to privately insured patients.

For all of these reasons, NAPH decided in late January to endorse the major principles and key provisions of President Clinton's Health Security Act.

It is not that we believe that the President's proposed bill is perfect, or that it cannot be improved. Indeed, we are concerned that the untested concept of "managed competition" cannot in the foreseeable future meet all of the health and social needs of low income residents of our nation's inner cities. However, we are convinced that the Health Security Act offers you an excellent foundation upon which to build a comprehensive, universal, mandatory health plan.

NAPH members believe that President Bill Clinton has offered Americans our best opportunity in over half a century to join the family of civilized nations that make adequate health care a basic right of citizenship. NAPH strongly supports President Clinton in this historic effort. NAPH members are unanimously committed to working with the President -- and with the members of this Committee -- to achieve enactment of universal, mandatory health coverage as swiftly as possible. We simply cannot afford to let this opportunity slip away, like so many others in the last 50 years.

In the remainder of my testimony, Mr. Chairman, I have provided the Committee with new information quantifying the scope of the crisis facing urban safety net hospitals and health systems, and have also spelled out a number of concerns and possible amendments we would like you to consider as you move ahead to mark up health reform legislation.

Less than two weeks ago, Mr. Chairman, NAPH released a new 170 page Special Report on the crisis facing urban safety net hospitals in America today. Let me illustrate the urgency of this crisis with a few facts from that new Report (copies of which have been provided for the members of the Subcommittee):

Safety net hospitals today are bursting at the seams, with an extraordinary volume of inpatient and outpatient care. 60 NAPH member hospitals across the nation averaged over 270,000 emergency room and outpatient visits and 14,000 admissions, and totalled 17.3 million emergency and outpatient visits, in 1991. Despite overcapacity in many parts of the hospital industry, NAPH members averaged a 79% occupancy rate in 1991, almost 27% greater than the overall average for hospitals in the 100 largest cities for 1990.

Between 1980 and 1990, low income patients were increasingly concentrated in just a small handful of inner city hospitals. Public general hospitals saw an increased Medicaid utilization during this period of 43.5%, and the increase in public university hospitals was over 39%, compared with *reduced* Medicaid utilization in private university hospitals of nearly 14%. The proportion of self pay patients also increased nearly 17% in urban public hospitals between 1980 and 1990, as compared with decreases of 16-41% in all other categories of hospitals.

In the largest 100 cities in the 1980s, the use of inner city hospital emergency rooms and outpatient departments increased by over 39% between 1980 and 1990, to nearly 100 million visits. Urban public hospitals represent just 7.4% of all hospitals but provided 18% of outpatient care and 19% of emergency care in 1990.

Some of the largest urban public hospitals provide a staggering volume of emergency and outpatient care that could be provided in a more appropriate setting if one were available. For example, Atlanta's Grady Memorial Hospital provided nearly 865,000 emergency and outpatient visits in 1990; Cook County Hospital, over 670,000; Los Angeles County+USC Medical Center nearly 645,000. Urban public hospitals in the northeast experienced the highest average volume of outpatient and emergency hospital care, with an average of 413,000 visits in 1990.

Emergency and clinic patients are waiting longer to see doctors or be admitted. 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.

Safety net hospitals continue to concentrate their services on low income patients -- serving as both hospital and family doctor for the uninsured. In 1991, 24% of all discharges and 20% of all inpatient days in NAPH member hospitals were not sponsored -- even by Medicaid. 37% of all outpatient and emergency room visits were also by uninsured patients.

Safety net hospitals also continue to be uniquely reliant on governmental funding sources. Just 12% of the gross revenues of safety net hospitals were derived from private insurance and 16% from Medicare in 1991, while 71% were attributable to Medicaid and "self pay" patients. Average gross revenues at NAPH member hospitals were \$92 million for Medicaid patients and \$78 million for self pay patients (who are typically uninsured and thus "financed" only by direct local governmental subsidies and other mechanisms such as Medicare and Medicaid disproportionate share hospital adjustments).

In other words, carrying out their missions of serving the poor and providing essential community-wide services, NAPH member hospitals would have lost \$3.2 billion dollars in 1991 without local taxpayer subsidies and Medicaid "disproportionate share hospital" (DSH) payments. Such payments enabled these hospitals to break even and keep their doors open; yet both sources of financing have come under pressure from federal, state, and local governments in recent years. 67 NAPH members surveyed had total revenues of \$12.2 billion and total expenses of \$12.4 billion. They would have experienced significant losses, however, if not for local taxpayer subsidies of \$2.1 billion. In addition, we estimate that these hospitals received net Medicaid DSH payments totalling approximately \$1.4 billion based on an analysis of 1992 DSH data. On average, surveyed hospitals relied on Medicaid DSH payments for 12 percent of their total revenue.

As a result of this funding crisis, the many community-wide services provided by safety net hospitals are in danger of deterioration as well. Trauma centers, high risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units -- all are overflowing, at a time when state and local budget crises often require reductions, not increases, in funding.

1. WITH RESPECT TO THE CONCEPT OF "ESSENTIAL COMMUNITY PROVIDER", NAPH STRONGLY RECOMMENDS THAT HOSPITALS AS WELL AS CLINICS (AND OTHER FEDERAL GRANTEEES) BE DESIGNATED ESSENTIAL COMMUNITY PROVIDERS, IN ORDER TO ENSURE CONTINUED ACCESS FOR LOW INCOME PATIENTS WHO RELY ON THESE PROVIDERS AND CONTINUED AVAILABILITY OF THEIR COMMUNITY-WIDE SERVICES.

NAPH accepts the concept of managed competition in principal and believes it can be given an opportunity to work wherever feasible. However, based on our extensive

experience serving the urban uninsured, we are concerned that managed competition may prove ineffective for many years in meeting the needs of some areas, including inner cities and isolated rural areas. We believe this is true for several reasons, including the lack of a sufficient number and variety of plans and providers to guarantee access and choice even for individuals who have been issued their "card", and the checkered history of efforts to introduce competitive models to such areas (such as the California PHP scandals of the early 1970s and the Florida scandals of the 1980s).

It must be recognized, in implementing "managed competition", that the playing field is not currently level for either providers or patients in the inner cities and remote rural areas. To be equitable, and to guarantee access for patients in such areas to the broadest range of health and social services, a plan must ensure that all safety net providers (including public hospitals that currently serve a high volume of low income patients, as well as health centers and other federal grantees) are automatically determined to be ECPs and given the opportunity to participate in (and be paid by) all plans serving these patients.

In that regard, the Administration includes in its plan the designation of certain providers as "essential community providers" (ECP), and provides additional support and assistance to the providers so designated (including the guarantee that they will be paid for services rendered to enrollees of all plans in underserved areas). While hospitals are eligible to apply to the Secretary to be designated ECPs, they are not granted the automatic designation granted to several other categories of providers. **NAPH believes it is essential that any statutory definition of ECP provide for automatic designation of certain hospitals as well as health centers and other providers.** For your information, I have attached to my testimony a copy of a position paper provided to the Administration early last year on this subject. Included in this paper are suggestions for a number of criteria that might be written into the statute in order to carefully target any automatic designation of hospitals as ECPs, including criteria already used in the past by this Committee in areas such as Medicaid drug pricing and the requirement under Section 1923(b) that all states designate, at a minimum, the highest volume providers of Medicaid and low income care as "disproportionate share hospitals".

The remainder of my testimony will describe a number of other NAPH concerns and recommendations with respect to health reform generally, and the Clinton plan in particular.

2. HEALTH REFORM MUST NOT BE FINANCED THROUGH ELIMINATION OR SUBSTANTIAL REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL PAYMENTS UNLESS OTHER PROTECTIONS AND PAYMENTS ARE SUBSTITUTED FOR THE HIGHEST VOLUME PROVIDERS OF CARE TO OUR MOST VULNERABLE POPULATIONS.

NAPH strongly supports a broad array of financing mechanisms for universal health coverage, including taxes on excess employee health coverage, so-called "sin taxes" on alcohol and tobacco, sliding scale cost sharing for higher income insured individuals, and increased Medicare cost sharing. We would also support a tax cap on the deductibility of premiums by both corporations and individuals.

NAPH's most serious concern in the areas of financing has to do with the apparent proposal to finance a substantial part of health reform through Medicare and Medicaid reductions generally, and through elimination of the so-called "disproportionate share hospital" (DSH) adjustments in particular. The DSH adjustments -- which this Committee has played a major role in enacting and improving over the years -- have been of great importance in helping safety net hospitals provide the broad range of additional services needed by low income patients and urban (and remote rural) communities.

With respect to Medicare, since the Medicare program will remain largely outside of health reform, we believe the Medicare DSH adjustment should remain intact. We further recommend that Medicare DSH payments be strengthened for the very highest volume DSH

providers (especially if there is an elimination or substantial reduction in Medicare graduate medical education funding, as is also proposed).

With respect to Medicaid, NAPH acknowledges that there have been numerous instances where states have used DSH funds for other than their intended purpose, and that with the phase-in of universal coverage this adjustment is unlikely to be preserved in its current form. However, it is important to point out that there are also many states which have not treated Medicaid DSH adjustments as a scam or a new form of revenue sharing -- which have used the adjustment as it was intended to be used, to fund substantial additional programs and services to Medicaid recipients and the uninsured poor. New data collected by NAPH and provided to Subcommittee staff shows, for example, that 100 of the highest volume providers of care to Medicaid patients and the uninsured collected over \$2 billion in net Medicaid DSH payments in 1992. These payments were essential to their ability to keep their doors open and preserve access for both insured and uninsured patients in many underserved urban areas.

NAPH therefore strongly recommends that Medicaid DSH be carefully phased out, not terminated abruptly, if universal mandatory coverage is enacted, with residual DSH payments targeted on the highest volume providers of care to the poor. Moreover, even if Medicaid DSH is carefully phased out, as noted in the previous section of my testimony, many residual community-wide public health and social services will continue to be needed even after most uninsured Americans have been given their "card". For these reasons, NAPH strongly supports the inclusion of the "vulnerable population" adjustment proposed in the Clinton plan, although our research and analysis indicate that this adjustment should be in the range of \$3 billion nationally rather than the \$800 million currently allocated.

3. NAPH IS CONCERNED ABOUT THE PROVISION AND FUNDING OF SERVICES FOR MANY INDIVIDUALS WE CURRENTLY SERVE WHO MAY NOT BE ELIGIBLE -- OR WHO MAY FACE SIGNIFICANT BARRIERS TO ENROLLMENT - - UNDER THE PRESIDENT'S PLAN.

One of NAPH's most important principles is that national health reform must be nothing less than **universal and mandatory for all residents**. While the President's plan has expressed the goal of universality, and appears to be mandatory for those who are eligible, NAPH is especially concerned that there are certain populations who will continue to fall through the cracks -- either intentionally or unintentionally -- and that there are other potential barriers to enrollment that, if not adequately understood and addressed, will have the same effect as being ineligible for coverage in the first place.

Two populations likely to be excluded from coverage that have generated considerable discussion to date are illegal immigrants and prisoners. NAPH members and other urban public hospitals serve a very substantially disproportionate number of both populations and will be especially hard hit if they remain wholly outside the system.

With respect to illegal immigrants, the vast majority of health care currently accessible to this population is in urban and rural safety net hospitals and clinics. This care is funded by a precarious patchwork of federal, state and local funding, augmented by cost shifting wherever possible. Recent federal programs such as SLIAG, which was targeted at legal (not illegal) immigrants, have in the past been able to pay for some of these services. However, most such funding has now been reduced or terminated, and House efforts this summer to add more money to the budget reconciliation bill failed. Unless either coverage or funding is made available in health reform, the potential exists for the situation of the population to become far worse. With the expressed goal of "converting" Medicaid and other current revenue sources into premium income for those populations who will receive coverage, it is likely that there will be far less ability in the future even than there is in already inadequately funded system today to pay for the care that will continue to be needed by this large population. We cannot make illegal immigrants -- or their health needs --

simply disappear by refusing to cover them under health reform. We must make some sort of provision for their care if we are to have a truly unified system.

With respect to prisoners, the issue is equally complex. Prisoners are today excluded from Medicaid coverage and denied many other rights. Their care is sometimes paid for by the criminal justice system that incarcerated them, sometimes by state or local governments through other means, and sometimes the cost of their care is simply absorbed by the public hospital that treats them. Because it is an unfortunate fact that many prisoners today come from segments of the population that had not previously been eligible for health coverage, the problem in the past has perhaps been less obvious and less troubling than it will be after health reform. In the future, however, all prisoners who are legal residents will theoretically have been eligible for coverage prior to their incarceration, and will again become eligible following their discharge. And while safety, security and the needs of the criminal justice system require simplicity in any health system, there is no logic to maintaining prisoners outside the new nationwide system if our goals are universality, cost containment through prevention and earlier treatment, and the broadest possible sharing of risk. While mainstreaming prisoners in alliances and plans may be impractical, clearly the entire system will benefit if targeted plans, perhaps backed by a nationwide risk pool, can be developed for prisoners.

In addition to immigrants and prisoners, NAPH is also concerned about other populations that may fall through the gaps or be unable or unwilling to enroll under health reform even if eligible. These populations include the homeless and the deinstitutionalized mentally ill.

As our experience with Medicaid demonstrates, there may be other significant barriers to enrollment even for many individuals who may otherwise be eligible -- especially in inner cities and isolated rural areas. In fact, given the complexity of the system and the need for cost sharing by all but the poorest enrollees, it is virtually guaranteed that many people will simply not sign up for a health plan, even if it is considered mandatory. Rather, they will present themselves to providers in the future as they do today -- sick or injured, addicted or mentally ill, homeless, often unable to provide us with basic information about themselves. Our experience also tells us that some inner city residents will actually sign up for multiple plans, either inadvertently or intentionally, or may conceal their previous enrollment in order to obtain care at a more convenient or familiar location. For these reasons, it is therefore imperative that the eligibility process be kept as simple as possible, that the additional costs to providers of treating and enrolling certain populations be taken into account, that providers must be able to rely on the presumptive eligibility of any individual who shows up in their emergency room, that careful outreach and patient education be provided, and that new systems include maximum protections against patient misunderstanding or abuse.

In addition, NAPH applauds the concept of a "risk adjusted" premium for plans to take into account the special needs of individuals with more serious illnesses, injuries, conditions, or personal situations (including income status). However, we are concerned that the development of such an adjustment may be complex and take longer than envisioned, and that many alliances and plans may well become fully operational well before such an adjustment is in place. In addition, we are concerned that the President appears to propose only that a risk adjustment factor be added to plan premiums, with no additional requirements or assurances that "risk-adjusted" payments also be made to those providers who will treat disproportionate numbers of those patients determined to be at risk of greater needs and higher costs.

Also of concern is the possibility of adverse selection and "targeted marketing" by some plans -- cream-skimming, if you will -- that will leave the sickest and the poorest to enroll in "public plans". NAPH believes that there must be substantial safeguards, including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients. Both tough rules and strict enforcement -- including criminal penalties - - must be included.

4. THOUGH ADEQUATELY COMPREHENSIVE IN MOST RESPECTS, THE PROPOSED BENEFIT PACKAGE WILL RESULT IN MANY UNCOVERED COSTS FOR SOME URBAN RESIDENTS WHO SUFFER FROM ALCOHOLISM, DRUG ABUSE OR MENTAL ILLNESS.

NAPH is please that the basic benefit package provides an **emphasis on (and in most cases, first dollar coverage for) primary and preventive care**. We also agree that it appears generous and adequate in most cases.

Our two major concerns with the contents of the benefit package are with the proposed limitations on mental health and substance abuse benefits. We are extremely concerned that, while these limitations may make good policy sense for healthy, educated, employed middle class Americans, they fail to address the much greater needs of many residents of our nations inner cities. For many individuals, these diseases are primary, not secondary, diagnoses, and substantial barriers to effective functioning. Left untreated, they have substantial implications for the quality of life of all urban residents, significantly increasing (for example) the likelihood of crime and violence in our nation's inner cities.

NAPH is also concerned with reports that some categories among currently eligible Medicaid populations -- and especially poor women and children who are eligible for Medicaid but not AFDC or SSI payments -- may lose many of the additional benefits they now receive.

5. IT IS ESSENTIAL THAT ANY MAJOR SHIFT IN THE FUNDING OF MEDICAL EDUCATION TAKE INTO ACCOUNT THE SPECIAL NEEDS OF SAFETY NET HOSPITALS AND UNDERSERVED PATIENTS.

NAPH strongly supports the need to develop more rational and broad-based funding mechanisms for medical education, and to shift our emphasis in medical education (as well as in patient care) away from specialization and towards primary care and prevention.

Because most NAPH member hospitals are major teaching hospitals, and rely on their medical education programs for both education and patient care, we have several concerns with certain ambiguities in the President's proposal, as follows:

- Major urban public teaching hospitals must be eligible to be designated academic health science centers or "affiliated hospitals" of such centers.
- With the reduction in specialty residencies, the criteria for allocation of such residencies in the future must include a clear reference to the importance of patient care as well as educational needs.
- In the shift away from specialty residencies, attention must be given to the fact that there are still many parts of the country -- such as inner cities and remote rural areas -- where there remain severe shortages in many medical specialties.
- Where a residency program encompasses several different and unrelated centers or hospitals, clear criteria must be spelled out for allocating the proposed medical education funding and ensuring an equitable apportionment among all major components of the program.
- The impact of health reform on the training of allied health professionals and on the ability to improve the proportion of minorities in all health professions must also clearly be taken into account in any such sweeping reform of our medical education system.
- The new system must also be carefully phased in over a period of time, and transitional funding must be available to affected hospitals and health centers whose teaching programs will be reduced or changed.

6. FINALLY, IN ORDER TO ASSURE ADEQUATE ACCESS AND A CAREFUL TRANSITION TO A NEW SYSTEM, SOME URBAN AND RURAL SAFETY NET PROVIDERS WILL REQUIRE ASSISTANCE IN GAINING ACCESS TO CAPITAL TO REBUILD THEIR INFRASTRUCTURE AND DEVELOP NEW NETWORKS AND PLANS.

Many supporters of various national health reform proposals have suggested that, if reforms were enacted, there would no longer be a need for an institutional health safety net. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the strong likelihood that future changes will continue to be incremental and piecemeal, NAPH believes that there will continue to be a strong need for the public health safety net in our nation's metropolitan areas.

We must thus be extremely careful about dislodging any current institutional funding mechanisms for public health systems in general, and safety net hospitals in particular, unless we are certain that we have a workable and fully implemented system to take their place. Moreover, we must continue to press forward with more targeted programs and reforms that support "stand by" health and social services and safety net providers.

For example, essential urban and rural safety net hospitals are likely to face a substantial need for assistance under health reform in obtaining adequate capital to rebuild and equip our nation's health infrastructure. A 1993 NAPH study estimates that there are at least \$15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed. NAPH has assisted with the drafting of a major new urban/rural capital financing initiative that was first introduced in 1992, and was reintroduced last year in both the House and the Senate. While its cost to the federal government would be only \$1 billion per year, this bill would create federal-state-local and public-private partnerships to finance up to \$15 billion in capital improvements for safety net hospitals, through loan guarantees, interest rate subsidies and grants to meet both general and specific safety net capital needs. **We strongly urge that this bill be adopted as a separate new title of any health reform legislation.**

In addition to capital needs, there are other areas in which infrastructure and "enabling services" must be funded to ensure a smooth transition to universal coverage. For example, it is important that funding be made available to improve the ability of urban and rural safety net providers to develop and finance regional provider networks that include a full range of services, including ambulatory and preventive care in addition to acute inpatient care, and to participate as effectively as possible in managed care programs and initiatives. It is also essential that the many health and social programs and services currently provided by public hospitals and public health departments be continued, and that the implementation of health reform not be permitted to diminish or reduce support for these programs and services.

In conclusion, for many reasons, even if national health insurance were adopted this year, America's safety net institutions will need continued support well into the future:

- Any new health reform system is likely to be phased in over a long period of time.
- Even with coverage, many of our current uninsured will be little better off than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.
- Many of the currently uninsured and underinsured also suffer from a variety of health and social problems very different from those of middle America. Conditions such as AIDS, substance abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education. While no health care

provider can fully cope with all of these problems, in many areas, our urban safety net hospitals are the only ones even trying to do so today.

- In addition, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside -- areas which, even if national health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.
- Finally, with the dramatic cost containment efforts already being imposed by both public and private payers, we must recognize that many expensive and unprofitable community-wide "standby" services (such as burn care, and neonatal intensive care, and the emergency and trauma services provided by Denver General, Los Angeles County and many of their counterparts around the country) are already under pressure and in danger of being reduced or eliminated in some areas; unless they are taken into account in health reform, the result will be a significant reduction in the security and health status of all of our citizens, not just the uninsured poor.

It is clear that there are many parts of our health system today that are not functioning properly, that need to be restructured or reformed. But it is essential to understand that we have relied heavily for many years on a fragile network of safety net institutions to fill in the huge gaps in our system, and this reliance will continue into the future even as we phase in universal health coverage. In other words, we have a network of unique hospitals in our nation today who have always been ready, willing and able to serve as "providers of last resort" -- to keep their doors open and their services accessible to all persons, regardless of race, creed, income, or insurance status. If the federal government generally, and this Committee in particular, are not willing to adequately support the existence of this "provider of last resort" capacity, it is clear that no one else will do so either, and this capacity will disappear.

I would be pleased to answer any questions you may have at this time.

Chairman STARK. Mr. Silva.

STATEMENT OF JOHN M. SILVA, PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, AND EXECUTIVE DIRECTOR, FAMILY HEALTH CARE CENTERS, ST. LOUIS, MO.

Mr. SILVA. Thank you, Mr. Chairman and members of the committee for the opportunity to testify before you. As the president of the National Association of Community Health Centers, I represent over 700 community, migrant and homeless health centers that are located in rural and inner-city communities throughout the country.

These are collectively known as federally qualified health centers, a term which, as you know, Mr. Chairman, this subcommittee played a central role in establishing in law.

I also serve as the CEO of Family Care Health Centers, located in St. Louis, Mo. I will attempt to bring some issues to your attention, both from a national as well as a front line inner-city perspective. I want to make three points for your consideration.

My first point is that health reform must include guaranteed universal coverage for a comprehensive benefits package defined in law, and that does not diminish the coverage the underserved now receive under Medicaid. We applaud the President and the Congress for getting down to the serious business of providing health care to all Americans.

As front line providers to the underserved, we are counting on you to hold firm on the line in the sand on universal coverage.

Moreover, that coverage must be affordable for everyone, at all income levels. I am deeply concerned that some of the proposals now under consideration would not provide affordable coverage, requiring some people to pay up to a sixth of their income for coverage.

At my health center, as in all health centers across the country, we operate a sliding fee scale, based upon Federal poverty guidelines, which assures that people who are uninsured and cannot afford to pay for services nevertheless have access to health care.

Currently, over 40 percent of Family Care Health Center's 18,000 patients participate in our sliding fee scale arrangement for their health care. Now imagine this population, which cannot currently afford the most basic necessities of life, having to pay 10 or 15 percent of their meager income for coverage, plus copayments for each service they seek. That would be devastating for the very poor, especially mothers with sick children.

The result is that rather than seek care as soon as health problems arise, low-income people would be forced to delay care until health problems become emergencies, endangering their health and increasing their costs as well as society's.

Further, if certain bare bones health plans offer particularly low out-of-pocket premiums, low-income people may have no choice but to enroll in them, reinforcing economic and racial segregation in the delivery of health care. That simply cannot be allowed to happen.

My next point deals with access to care or the underserved. As many in the Congress have already noted, for health care reform

to succeed—particularly the goal of cost containment—it must provide universal access to primary and preventive health care services as well as universal coverage.

As we know all too well from our experience over the years with Medicare and Medicaid, possession of a “health security card” will not necessarily guarantee access to health services. Nowhere is this more true than in America’s inner-city and rural medically underserved communities.

Who are the underserved? In simplest terms, they are people who can’t get care when they need it, when it makes the most sense, when it can prevent the onset of illness or treat it early, because of who they are, where they live or ironically because of their complex health and social conditions.

A recent report by my organization and the George Washington University found 43 million such people, living in urban and rural communities all across the country. These Americans need more than universal coverage and comprehensive benefits; they need a medical home that responds to their unique needs.

Health reform must therefore include a substantial commitment of resources for primary and preventive care infrastructure development in underserved areas, on a guaranteed funding basis, as a central part of health reform.

I am pleased to note that several of the bills under consideration including those sponsored by Mr. McDermott, Mr. Gephardt, Mr. Thomas, and Ms. Johnson all call for significant new funding to these very programs.

I should add, however, that only Mr. McDermott’s bill calls for guaranteed funding for this effort; and that his bill, as well as those by Mr. Thomas and Mr. Gephardt, call for roughly equivalent levels of support, which would meet much, but by no means all of the need out there. It is no secret that the health center programs have been uniquely successful over the last 30 years.

It is also no secret that they continue to be horribly underfunded. America’s health centers are currently reaching only 15 percent of the 43 million underserved and funding for the program has not kept up with the general inflation rate. If you and the Federal Government are sincere in your interests to provide health care to all Americans, you must guarantee access to community-based, consumer-directed, affordable, quality, primary and preventive care to all, and especially to the underserved. The model is out there, it just has to be replicated.

My health center will provide over 70,000 patient visits this year. It will provide the majority of those visits in a 12,000 square foot converted grocery store that maxed its capacity back in 1985 when the organization provided 24,000 patient visits annually.

You can imagine how cramped we are as we continue to meet the demand for service. We simply do not have the physical capacity to be able to accommodate the demand for service, and not being a large hospital or HMO with a huge capital reserve, we can’t simply go out and expand or build a new facility.

We have recently, however, opened a smaller satellite health center in another high-need and I might add, high-crime area of St. Louis, and literally before the doors have opened, we are at max capacity.

Any health care reform legislation that seeks to only reform the way health care is financed clearly and completely misses the point. For health reform to work in underserved areas, if the underserved are to have access to health services to stay healthy and hold down costs, it must build on what has worked in those communities and include a substantial infusion of capital into those high-need areas, not only to expand current primary care providers and develop new ones where needed, but to support the operational costs of caring for a very sick and hard-to-serve population. The underserved also need the assurance that their medical home will not be driven out of business due to excessive financial risk or inadequate reimbursement, simply because they care for those who are sickest and hardest to reach.

I think all of us here know that much of the managed care industry and "established" providers are not going to care for the inner-city and rural underserved, the poor, disadvantaged minorities and other vulnerable populations whether they have third-party coverage or not.

The incentives in managed care are all wrong when it comes to the underserved. It is easier for the managed care industry to just avoid these people than it is to try to understand their needs and manage their care. This is the Achilles' heel of managed competition, or any reform plan with roots in managed care: If underserved populations' primary and preventive care needs are not met, cost containment goes out the window.

These are exactly the kinds of people who end up on emergency room doorsteps. In this context, health reform must also offer strengthened contracting rights and safeguards for federally qualified health centers and rural health clinics assuring the preservation of the existing "safety net" in underserved communities and their full participation in the new health system.

Currently, the President's bill and, to a lesser extent, Mr. Thomas' bill, call for such safeguards, but they need to be strengthened even further. My health center colleagues from New York to Texas and California have been approached by the big health plans like Aetna and Cigna, who want them to take care of their sickest enrollees, but are not willing to pay them a rate that recognizes the inherently higher costs of serving such a population.

One closing thought: If my single health center, located in St. Louis, Mo. had access to capital dollars for infrastructure development, we estimate that last year alone instead of 18,000 patients we could have provided services to 30,000 patients, which would have represented not a little over 70,000 patient visits, but close to 125,000 patient visits to the medically needy, the medically underserved, the poor, and high-risk or special populations.

Instead, those folks that can't get into centers like mine or have to wait, and instead become part of the crisis within emergency rooms and the health care system. Give us the tools and the resources; we have proven we can make it work.

Thank you for the opportunity to appear before you today, Mr. Chairman. I will be glad to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF
THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
ON NATIONAL HEALTH CARE REFORM
AND UNDERSERVED AMERICANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, the National Association of Community Health Centers (NACHC) is the national membership organization of over 700 community, migrant and homeless health centers providing comprehensive primary care services to over 7 million medically underserved Americans in 1400 sites across the country.

NACHC and its member health centers are well aware of the failures of our health care system, in particular because we care for millions of Americans who have been forgotten or left behind -- unserved, or poorly served at best -- by the existing health care system. In this context, health centers strongly support the President's call for meaningful health care reform to provide universal coverage to all Americans that can't be taken away, and improve access to care -- especially to preventive and primary care, and contain health care costs.

The needs of the underserved in health care reform are clear, and attainable this session of Congress:

- The underserved need a place to go for entry into the health system -- a medical "home" that responds to their unique needs, that is geographically and physically accessible, culturally and linguistically competent, and available during evening and weekend periods; and that offers comprehensive primary care and "enabling" services, like transportation, translation and outreach. Universal coverage, though essential, is not enough, as health insurance alone will not necessarily guarantee access to needed health care services;
- The underserved need an adequate supply of physicians and health professionals who are trained to understand and respond to their unique needs and health care problems; and --
- They need the assurance of knowing that the essential community providers which have historically served them will be able to continue doing so, through initiatives that provide adequate reimbursement (taking into account the inherently higher costs of caring for them) and risk contracting safeguards designed to protect their fiscal solvency.

Clearly, we now have the best opportunity in over half a century to extend access to affordable, quality health care to every American. **We want to work with the President and Congress to capitalize on this golden opportunity -- let's make health care reform work for all Americans.** As presented, the President's plan makes several vital contributions toward improving access to health care and ensuring health security by:

- extending comprehensive coverage to millions of people who are currently uninsured or inadequately insured, with benefits equal to or better than those offered by many of the largest companies;
- eliminating the most brutal current health insurance industry practices of denying or discontinuing private insurance coverage because of previous or current health conditions, or due to a change or loss of job;
- proposing to substantially reorient our health care system -- including the training of physicians and other providers -- to focus more on low-cost, high-payoff preventive and primary care, including coverage of important preventive services;

- proposing to expand and improve preventive and primary health services in underserved rural and inner-city areas;
- recognizing and safeguarding the key role of health centers and other "essential community providers" in caring for low income and underserved communities.

With the inclusion of these elements, President Clinton's proposal lays a solid foundation for achieving effective national health reform, and for ensuring that every American -- no matter what their circumstances -- has access to affordable, quality health care. Many of these elements are shared by the single-payer proposal introduced by Representatives McDermott and Conyers, and to lesser extent, the Senate Republican proposal written by Senator John Chafee. However, with the notable exception of the single-payer plan, many of the other proposals for health care reform -- particularly the "managed competition" approaches, which have received so much attention of late -- contain elements that raise concerns about how well or poorly the system will meet the needs of the underserved.

The proposals, most notably the Health Security Act and the Managed Competition Act sponsored by Representative Jim Cooper, rely heavily on a system of managed competition, under which several health plans -- most of the managed care type -- will compete for Health Alliance enrollees, ostensibly on the basis of price and quality of care. This focus on managed competition could work to assure care and at the same time contain costs for most Americans. Yet while managed care has been cited frequently for its successes in effectively organizing available local health resources to hold down the cost of care, there is no evidence that the presence of managed care in a community has successfully increased the level of available resources there, a critical factor in improving the health of underserved communities.

Moreover, most managed care entities and HMOs have historically avoided the underserved because of their unique needs and inherently higher costs. In a market-based, competitive health system with a foundation in managed care, the most expensive patients -- the underserved and those in greatest need of health care -- could encounter significant discrimination and barriers to obtaining health care services. For some areas and populations -- in particular low income, rural and inner-city minorities, and other at-risk Americans -- this approach may not improve access to care, and could even prove detrimental. What is absolutely clear to us is that a safety net will still be needed in a reformed system under a managed competition approach -- a "front door" into the health care system that is significantly influenced by the medically underserved themselves.

Our concerns are further heightened by the limited nature of proposed federal cost-sharing assistance for low income persons and families in the various proposals for health reform. In this respect, the President's plan is among the most generous; other bills have severe limits. Nearly all bills would limit subsidies to the premium charges by plans that are at or below the weighted-average premium. This limitation could effectively restrict the choice of poor persons to only low cost plans, thus running the risk of creating a de facto two-tier system. Similarly, even the poorest Americans will face some cost sharing, including copayments for doctor visits and prescription changes. This burden will have its most telling effect on pregnant and postpartum women, infants, and those with chronic or complicated illnesses, because they will need frequent care and multiple medications.

Some of the many potentially serious problems that could be faced by low income Americans and the working poor in a managed competition-based system include -

- **Severely Restricted Choice of Plans or Providers:** Because of the restricted subsidies under the managed competition proposals, individuals with family incomes below 150% of the Federal poverty level are unlikely to be able to afford the premium surcharges for higher-cost plans. By this standard, 60

million people -- 25% of the entire population -- will be able to choose only among the lowest-cost plans, and will be subject to the discrimination and poor quality often associated with the Medicaid program. It is unclear whether or to what extent low-income and other medically vulnerable populations will be assisted to enroll in plans, select a plan that works best for them, and to obtain the care and services they need, which in many cases go beyond the care and services included in the required package and furnished by traditional plans.

- Lack of Plan Capacity: Those who can afford only a low-cost plan may find there are not enough such plans available with enough capacity. Few plans will be willing to market coverage at the premium charged by low-cost plans, and will instead target employer-insured families.
- Increased Discrimination and 'Redlining': If the new systems is inadequately financed, health plans will have every incentive to avoid areas with high numbers of low-income people. Fly-by-night or "lowball" plans may well be the only providers bidding for coverage in these low income-areas -- resulting in diminished access and lower quality services for all enrollees there. Depending on how Alliance and plan service areas are delineated, major redlining could occur, with low-income, racial/ethnic minority, and high-risk populations gerrymandered into segregated Alliance and plan service areas and subject to less oversight and poor quality care. The experience with redlining under Federal voting rights and credit lending laws suggests that no duty not to redline can counteract wide discretion in drawing identifiable service areas.
- Obstacles to Specialty Care: Lower-cost plans are more likely to require stricter utilization review and place more obstacles between low-income patients and specialty care. In particular, persons with chronic illnesses or disabilities may be adversely affected if plans are permitted to severely restrict out-of-plan referrals or payment for specialized care and services. Also, plans will presumably be required to cover out-of-area services (at least for emergency/urgent care needs). However, it is not clear yet how this will work under the President's or Representative Cooper's plan. This is a critically important issue for migrant farm workers, transportation employees and others whose work requires frequent and extensive travel, and involves multiple employers.
- Inadequate Monitoring of Quality and Access: Based on the experience with Medicaid, states and Alliances may not be able to adequately monitor quality and access in low-cost plans, especially when faced with the pressing need to hold down the cost of care.

Simply put, underserved Americans are in the health care predicament they are in because they have been rejected by the private market. The community and migrant health center programs were enacted by the Federal Government in response to the failure of market forces to meet the needs of underserved and vulnerable populations. Thus, if market forces work for health care like they have worked in other sectors of the economy, underserved people and communities run the risk of being red-lined, short-changed and, in the end, getting far less care than they need or deserve.

Finally, undocumented persons will be ineligible for coverage under virtually all major proposals, and are barred from receiving public subsidies or employer-subsidized benefits under the managed competition approaches (thus disqualifying millions from the employer coverage they now have). All hospitals presumably would still be required to furnish emergency care to undocumented persons under Federal anti-dumping law, but potentially hundreds of millions -- if not billions -- of dollars in uncompensated care would remain, with as yet no clearly identified funding source to cover the cost.

These concerns underscore the critical need for a substantial, Federally-administered "safety net" for millions of disadvantaged and underserved Americans, even after reform is implemented. The Health Security Act acknowledges this principle, but its response falls seriously short on some key elements. For example:

- **Access to Care:** The Health Security Act's Access Initiative calls for a vital investment of about \$4.5 billion over 6 years in the expansion of primary care services in underserved areas, in assisting in the formation of service delivery networks, and in furnishing key 'enabling services,' such as transportation and translation services, to those living there. Similar efforts are proposed in many of the other bills, as well. We strongly support the basic purpose of this Initiative and believe that the levels proposed by the President are minimally adequate to meet the need for such efforts (greater efforts are called for in the single-payer bill, at \$4.8 billion over 6 years, and in the Chafee bill, at \$5.6 billion over 5 years). However, nearly all of the President's funds would be administered under a *totally new, discretionary program*, which would give greatest preference to entities, including non-publicly assisted HMOs, private doctors and other institutions, with little or no community involvement or accountability; publicly-funded providers who band together are given a lower preference for receiving support.

What's more, we see it as a vote of no-confidence on the ability of disadvantaged and minority communities to positively influence the structure and character of their community's health care system. In our view, this represents a significant change of heart by the Administration on its early guarantees that health reform would help empower medically underserved communities.

Further, the discretionary nature of this new program (which is also found in other health reform proposals, with the exception of H.R. 1200) raises the distinct possibility that existing programs, such as the health centers, Family Planning, MCH, and Ryan White, which will continue to fill vitally important purposes even after reform is implemented, will be pitted against proposed new programs for scarce federal resources. Senators Fritz Hollings and Tom Harkin and Congressmen Dave Obey and Lou Stokes have fought as hard or harder than most other Members of this institution for funding for these programs, yet have been unable to keep their funding on par with general inflation, much less health inflation. A discretionary funding construct for a health reform access initiative raises the distinct probability that funding levels for these programs will never be adequate. The Managed Competition Act contains exceedingly limited resources, none of which could be used to expand capacity in underserved areas. The Chafee and House Republican bills do contain resources for this purpose, but as put forth, could not be used for the formation of community-based networks and plans. Only the single-payer bill guarantees funding for these purposes. Given what is at stake, we feel that mandatory funding is the only viable approach.

- **Essential Community Providers:** We applaud the Health Security Act for its unique and vital provisions that would recognize those who currently care for the underserved (such as community, migrant and homeless health centers, family planning clinics, and Maternal and Child Health clinics) as "essential community providers" (ECPs), and extend certain rights, such as contracting and payment requirements, for the first five years after reform begins. These protections are found in only one other legislative proposal -- that of Senator Chafee, where they would apply only to providers serving the Medicaid population, or about 15% of all eligible Americans.

Under the President's bill, all health plans are required to contract with ECPs in their service area. ECPs that elect to contract on an "in-plan" basis (most

health centers are likely to do this) will be paid no less than other providers for the same services by the Plan. ECPs that contract on an "out-of-plan" basis (most likely, school-based clinics, health care for the homeless, etc.) will be paid based on the Alliance-developed fee schedule or the most closely applicable Medicare methodology (for a health center, FQHC cost-based reimbursement), at the ECP's choice.

While these safeguards are critically important, we fear they do not offer adequate protections for ECPs. Most importantly, ECPs get precious few safeguards from risk-based contracting by health plans. Risk adjustments and reinsurance are required only for the health plans; there are no provisions requiring that they be shared with contracting providers -- not even the ECPs who, more than any other, will face the inherently higher costs of caring for sicker and harder-to-serve patients. A possible scenario, even with the Health Security Act's safeguards: a health plan agrees to contract with the ECP, but on a risk basis; the health plan assigns the ECP the sickest patients, and pays the ECP no less -- but no more -- than other providers for the same services, with the ECP at risk for any costs in excess of the health plan's capitated payment. The ECP is out of business in 2-3 years.

NACHC believes that one overriding policy should govern the construct of an Essential Community Provider initiative: those providing comprehensive primary care services to the underserved should be paid an adequate rate, and should be exposed to minimal risk. Ensuring the continued function of essential providers will be absolutely critical if we are to encourage more caregivers to provide primary care, especially where it is most needed, and ensure that more of the underserved receive primary care and preventive services.

- **Health Professions Education and Placement:** The Health Security Act, as well as most of the other major reform bills, calls for substantial reform of the nation's health professions education and training efforts, and restructures its financing. However, it leaves the lion's share of the resources in the hands of the nation's medical schools and teaching hospitals -- which have played no small role in the current oversupply of specialists and our critical shortage of primary care physicians.

None of the legislative proposals effectively involve health centers in the training and education of health professional, again with the exception of H.R. 1200. Community health centers affiliated with teaching programs have produced hundreds of family physicians, general internists and general pediatricians -- exactly the kinds of doctors our health system desperately needs -- yet they get nothing in the way of direct funding to continue or expand their educational efforts. Currently health centers with teaching programs are required to affiliate with a sponsoring medical school or teaching hospital. Payment for the costs of the health center's educational program is made on a "pass-through" basis with the sponsoring institution. The result is that many "teaching health centers" end up eating a substantial portion of the costs of their educational efforts. Further, the availability of residency opportunities in community and migrant health centers is directly linked to the availability of teaching hospitals willing to engage in educational partnerships with them.

We'd like to have direct access to medical education funds so we can provide practice opportunities for medical residents and expose more medical students to the benefits of providing primary care in an underserved area. The available literature shows that where medical residents and other health professions students are exposed to primary care training in a community-based setting, significant numbers enter primary care as a practice. For the reformed health system to function successfully, it will have to generate significant numbers of new primary caregivers. Community and migrant health centers anxiously

await the opportunity to participate in those professionals' education.

Making Health Reform Work for Underserved Americans

We believe that, if health reform is to work for underserved Americans, it must empower medically underserved communities to develop workable, permanent, responsive community health care systems, through steps to provide:

- a substantial investment of guaranteed resources for the formation of community-based, consumer-directed health plans and networks, and to increase access to primary and preventive care in underserved areas; through support for key programs that now support vital services to disadvantaged and underserved populations (including the health center programs, Family Planning, and others).
- strengthened safeguards for Essential Community Providers that assure preservation of the existing safety net in underserved communities, and their full participation in the new health care system, including safeguards against excessive risk in contracting with health plans and payment of rates that acknowledge the inherently higher costs of serving underserved populations;
- direct funding for community-based training programs for primary care health professionals in order to assure adequate primary care educational opportunities for students in the most appropriate settings -- where they are needed most.

NACHC is in the process of developing perfecting amendments to the various health reform proposals to meet these critical objectives.

The most pressing need of -- and the most rational response to -- the medically underserved under any health care reform approach is increased availability of community-responsive, consumer-directed, comprehensive primary health care services, particularly under a market-driven approach to reform where the bottom line will take absolute precedence. Yet more can and should be done than just investing in service development: the lesson of the health center programs is that, although it may not be possible to empower communities to take control of the entire new health system, it is possible to empower them to own and operate their own entry points into it. Health centers were founded with a vision of community and consumer empowerment, and their experience over the past 30 years provides an object lesson on how consumer involvement and community empowerment can succeed where other models have failed. In this sense, health centers may be the last, best hope for communities in shaping their health care system and making it responsive to their needs. For obvious reasons, we strongly believe that any access initiative worthy of the name should retain and significantly expand upon the health center model because:

- o it is a proven model of getting Federal funds to improve the health of hard-to-reach populations to the areas that need them most;
- o health centers represent a multibillion dollar investment by the Federal government in primary care infrastructure in underserved communities over the last 30 years, and attracting and retaining health professionals in shortage areas;
- o have proven their effectiveness, cost efficiency and quality, and success in;
- o it is a proven model of empowering underserved communities to manage their own points of access into the health system, and to tailor the services provided by the center to the unique needs of the community;

- o the centers' are accountable for efficient utilization of Federal funds and quality of services provided, and are subject to strict monitoring and oversight by Federal agencies, unparalleled in the private sector.

Polymakers should look hard at what has worked and why, and what has not worked for the underserved:

- o Who has provided culturally competent care and ACCESS to these communities? Who has not?
- o Who has seen all regardless of the ability to pay? Who has not?
- o Who has kept costs in check while developing innovative approaches to meeting the health needs of these communities? Who has not?
- o Who has attracted, trained and kept physicians and qualified health professionals in underserved communities? Who has not?
- o Who has genuinely empowered communities to develop long-range solutions to their health care needs? Who has not?

Members of Congress can and must make sure that health care reform "stays on track" and works for our Communities. Congress knows what works and should renew its commitment to Community Health Care. This is not about a program, but rather an approach to empower communities to develop and direct long range solutions that will work for them -- in keeping with the President's principle of responsibility, which we all support.

In summary:

- President Clinton made a commitment to equality of access to health care. We fully support that pledge, and believe that health reform must work for all Americans, and especially for the medically underserved.
- There is much to admire and support in the President's proposed plan and those of other Members; at the same time, some elements cause considerable concern about how well these plans will address the most pressing needs of underserved Americans.
- Health care costs will never be controlled unless high-risk, underserved populations have access to primary and preventive care. Health insurance while essential, will not alone guarantee access to needed health services.
- Health reform should build on what has worked: the community, migrant and homeless health center programs. Nothing else has our uniquely successful, 30-year track record of controlling costs, providing access to quality care, retaining health professionals where they're most needed, or empowering communities to develop long-range solutions to their health needs. Health reform should invest in such successes.
- We are committed to support and work with the President and the Congress to ensure the earliest possible passage and enactment of an effective, comprehensive national health reform plan this year.

Thank you.

Chairman STARK. Mr. Thomas.

Mr. THOMAS OF CALIFORNIA. We have looked at all these statistics, but the thing that keeps coming home, when you say that 21 percent of the folk are rural, the answer I get from my people is I may be 21 percent to you, but I am 100 percent to me. That is even more so of the three-quarters of the folk who are urban.

I understand where you are coming from in terms of supporting the single payer. My only question is what is the price tag?

Ms. ROSENBAUM. If you take just the community health center's program it would probably take several billion dollars to both build the number of facilities that are needed and provide them with the operating subsidies that they require above and beyond the insurance payments they would receive. That is they would need subsidies in order to provide uncovered services, to provide the enabling services to protect themselves against undue financial loss.

I am sure John has better statistics than I do. I would guess that the cost shows up not even a measurable fraction of a percentage of the Federal health care budget. Now whether or not Congress chooses to adopt a single-payer insurance system, the strength of the Wellstone-McDermott bill on this particular issue is that the payment for the capital and grant moneys needed to develop services and keep them going in poor communities, underserved communities, is built into the payment structure. It is certainly plausible to imagine taking that kind of a model and using it in a private insurance system just as the President's bill does for academic health centers.

Mr. THOMAS OF CALIFORNIA. That was why I was pleased that Mr. Silva was knowledgeable enough to indicate that most of the comprehensive plans, even if they don't endorse either single-payer structure, or a government-run system or even the President's mandatory structure, that we are all concerned about the area and that we are all putting money in the area and sometimes holding your own or treading water is ahead of the game if other areas are slipping. My concern is that this area under any plan will not get the kind of attention that is necessary.

Mr. Silva, my question to you goes to testimony that that we had several days ago. Frankly, I was a little bit excited about it. In my area there are some programs that appear to be making some headway. Both my counties are part of the pilot program for managed care under the Medicaid shift. But in terms of clinics, testimony from Boston, which is now extended to the entire State of Massachusetts, testimony in the Chula Vista area of San Diego and the entire State of Arizona has indicated that there seems to be some folk out there who are making the current system work and work in a very positive way.

Have you seen some creative approaches to dealing with this question in terms of the underserved area? In other words is it really structure—it is always structure to a certain extent? I was struck by these people who didn't let the structure get in the way and they didn't complain about the fact that there wasn't any money. In fact, they have gone out and organized it in such a way that other affluent groups are trying to attach themselves to them.

Are these anomalies and did we wind up with an efficient staff finding a couple of folk who could present a bright picture that isn't

going on out there? With all the changes at the State level, isn't there some innovation going on that we might point to as models that don't necessarily take just more money but take creativity and an understanding of what works?

Mr. SILVA. I think that you could look at the community migrant health center program in toto and go into almost any community, even a rural area where there is a community or migrant health center and basically say the same thing. To give you an example of that, there are so many entrepreneurial and innovative approaches that are being taken by community-based programs that it is literally staggering, but I need to stress that they are community-based and consumer driven, and a lot of times they have had to survive without mainstream medical support, without mainstream financial support, without any type of State or administrative support.

Mr. THOMAS OF CALIFORNIA. Are you saying that sometimes, maybe, that is the reason they are succeeding?

Mr. SILVA. No, I think they are succeeding despite it. I sometimes am awed by the thought that, if there was ever a time when there would be administration and establishment support for these types of grass roots organizations, what kind of constructive things that they could do. If there were additional resources that were available based on their track record of entrepreneurial development and services, how many more people they could provide services to.

Mr. THOMAS OF CALIFORNIA. That is one of the reasons that we put the component that you were kind enough to mention in my bill, because in my rural central valley California district the migratory health centers are one of the bright spots. Not just by meeting the needs of the underserved but by creating cutting edge technical opportunities for people who would otherwise participate in an ordinary medical structure, and are being attracted there so there is a coming together of all parts of the community in the centers.

At one time, there may have been a slight stigma attached to them but there is a great deal of pride now. The new construction, the new building, the dentist facility, all those are tied to these health centers. I think there is a great opportunity in terms of a willingness to just do the job and be creative, but the funding has to be there.

Mr. Bernstein, there has been a lot of verbiage about coverage versus access and access versus coverage and we don't just want access, we want coverage. I think I understood what you meant in terms of you want to stress access rather than coverage. You are talking about the ability to deliver rather than the comfort of saying that you are covered. What good is a plastic card if you don't have a place to use it; is that basically what you are saying? I know that is a kind of a mine field when you get into coverage versus access. Maybe you ought to spend a minute to make sure everybody understands that you are not choosing sides in the political rhetoric contest here. You really mean something when you say you want access. Coverage is important, but access is primary and fundamental.

Mr. BERNSTEIN. That is what I mean. I have some suggestions but they are my own, they are not the association's on the issue. It seems to me the more you listen to the debate the more I understand the cost of the reform is going to be—could be quite astronomical, and I enjoyed the little repartee between the chairman and Dr. Lee, but I think we are going—most of the plans are going about the concept of access and missing the boat on one very important issue. They are not to me recognizing where the real economic force is in this whole managed competition debate. The force and what the plans are trying to do—and I believe we need to do this—is to put a lot of money into grant programs and I am all for that. I am involved with many, many programs, whether public health, community health centers, national health service—we need that money but we are betting the house that you can fund those programs. I think in addition to that we need to recognize that these big companies, insurance companies, HMOs, these big hospitals, the forces that they want to play in this game—and if we don't harness them in some way so that they benefit rural and inner-city underserved areas, we are missing the boat.

What I mean here is that we need to figure out creative rules and I don't see rules in these managed care bills. We need to figure out rules that say if you want to play this game, then we need a strong infrastructure. You need to support our community-based programs. We need to add to them in our rural inner-city areas.

We let you do that collaboratively. We will let you combine Kaiser, put money in and Prudential, put money in but we would set the standards for inner-city and underserved areas and rural areas so they wouldn't be able to participate—like you were talking about redlining, that is a must. If you let them chop off the best parts of the geography we really have a problem. But if we make them participate, invest in these areas, I think we can cut down on the overall cost of the total program.

But if we are going to just add on money that the Government has to come up with, I am concerned about that.

Mr. THOMAS OF CALIFORNIA. I think all of our concern is rather than sit in an academic criticism of the current system and make changes in the law and assume it is going to be fixed is, those folks who identify themselves in whatever percentage group understand they are 100 percent of themselves and that if they aren't getting the kind of medical coverage they at lease define as minimum, whether you call it access or coverage, they have been left out and that is the last thing that we should be doing.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Ms. Rosenbaum, I was struck and moved by your testimony as it relates to inner cities. You make a strong and compelling case that because of years of neglect, maybe generations of neglect, many of the health problems that we are facing in the inner cities of our country and in many of our rural areas is because of what we failed to do in the past.

I would like for you to give us some idea about your thoughts and concerns how we can provide civil rights protection in a new

world of health reform or the new world order of, the American order of health reform.

Ms. ROSENBAUM. As we move into health reform and rewrite health policy for the United States we are also rewriting a huge raft of related laws.

One of the great bodies of law that is being rewritten and should be rewritten to reflect a changing health system is the body of civil rights law in the United States. I have spent 20 years as a health and civil rights lawyer now and have spent a lot of time with colleagues talking about what kinds of protections would be required based on our experience with discrimination in health care and the kinds of plan that seems to be emerging.

As Representative McDermott pointed out before, very strong protections are needed at the level of drawing the market areas or the service areas, the pooling areas for the organization of the health care financing system. Whether those organized areas are voluntary or whether they are mandatorily drawn as in the case of the President's plan, there is great concern on many persons' part, and I believe it is one of the great strengths of the President's plan, that those boundaries not been drawn in ways that either intentionally discriminate, or the effect of discriminating.

I recommend that in addition to the establishment of standards for drawing the boundary lines that Congress give serious consideration to something akin to the kind of preclearance process used under the Voting Rights Act. Depending on the kind of bill that is developed, you could have a gerrymandering of health service areas that for all practical purposes, whether or not patients can go interstate, intrastate, or anywhere else for services, makes the financing of care virtually impossible in poor areas.

Beyond that and most profoundly from my experience is behavior of health plans themselves. As we move into managed care, whether we getting there under the gun of a bill or because we are drifting there anyway, we have now collapsed the financing of care with the access to care and along the way have come a series of unfortunate incidents, some of which you heard about last week in the managed care testimony. We see these problems every day.

The most important issues in managed care are nondiscrimination provisions in the selection of the marketing and service areas, with nondiscrimination standards not only on the basis of race and national origin but on the basis of socioeconomic status, perceived health status, gender and other suspect classifications.

If we use a community rating system, the whole risk underwriting of health insurance is basically gone and we have to rethink what it means to discriminate. When it is your job to discriminate, you get to be exempt from civil rights laws. When you no longer can risk underwrite, then the bases for discrimination on the basis of actuarial assumptions also goes up in smoke.

Another great concern is the role that essential provider provisions play for people. Those provisions have received the most publicity with respect to certain health providers who either do have the status or can apply for the status. The real purpose behind those protections had much less to do with protecting providers than as a means of preventing health plans from cherry picking providers who only see certain patients. If you take people's normal

source of medical care which is a community health center or public hospital and you shut that normal source of care out of a managed care network, people are cut off from their services. The immediate impact is a dramatic drop in use of care because people are afraid to come to a new provider or they don't know how to get through the door of a new provider. They have lost their health care home.

When you think about the essential provider protections you should think of them in the same category as any provisions that directly relate to nondiscrimination by the plans. I would be happy to go through the issues in greater detail with you, but it is at both the alliance level and the health service delivery level that you need to be concerned.

Mr. LEWIS. I appreciate your response. Mr. Silva, what else can we do to encourage the creation and continuation of medical homes. I understand community health centers need funding. What else can we do as a Congress; is there anything we can do under this proposed administration?

Mr. SILVA. I think there are a number of things that Congress can do and can propose from a front line perspective: Access to capital, infrastructure investment, dollars. I know everybody comes before Congress and wants dollars. I think it would be fair for me to say that an analysis of the community, migrant homeless health center programs will show you probably the best investment of Federal, private and community-based resources that has been experienced since the days of OEO.

I was going to say earlier that under the chairman's leadership with Federally qualified health center status, even in my same cramped quarters, we went from providing 43,000 patient visits 3 years ago to 71,000 patient visits this current year in basically the same space, and that was due to an influx of additional resources. If the infrastructure is developed and invested in we can take care of an awful lot of those 43 million uninsured. But when forced to compete with what we call the big boys, the large HMOs, the major health plans, we can't compete at that level.

We can compete in the communities and bring people into health care. I think an acknowledgment of that and I think we need some basic controls on Medicaid waiver approvals to make sure that in the name of cost savings that we are not throwing the baby out with the bath water as we appear to be doing in Tennessee and some other locations where we are literally decimating those providers of care to the uninsured, the poor and rural Americans in the name of Medicaid reform.

If Congress looks at the waiver process and how it is being applied, I think those two activities more than any I can think of right now would assist us in expanding those services. You know, in Atlanta you have some of the best health centers doing some of the best work in the country. We just need more of them.

If you are going to invest resources, start at the grassroots and work your way up and invest in community and migrant health centers.

Mr. LEWIS. Mr. Gage, you mentioned Grady. You mentioned that in 1990, Grady provided nearly 865,000 emergency or outpatient visits. Along these lines can you explain the importance of financ-

ing for capital improvement for public hospitals like Grady? You know Grady is undergoing a \$300 million capital improvement effort.

I think most of those resources came from the citizens of two metropolitan counties that serve Atlanta and De Kalb County.

Mr. GAGE. Well, Grady is in the middle of a major rebuilding process and the fact that they have among other things, I think it is the single highest total of outpatient emergency visits in the country of any public hospital, 865,000 sounds right. There are others that were cited in the testimony.

To follow up on the response to your earlier question, Grady was quite fortunate that Fulton and De Kalb Counties, which are the two counties that formed the hospital authority that operates Grady, are growing, are reasonably prosperous, they have very significant problems with the inner-city and with underserved areas; but Atlanta is one of the success stories certainly of the southeast, and therefore they were able to sell bonds basically that were backed by the citizens of the counties. That is very important to understand because it means that infrastructure support in Fulton county didn't cost the taxpayers directly.

They were able to sell bonds and the Grady and the hospital authority itself will pay those bonds back over a number of years out of revenues from current patients and certainly from the counties. They get well over \$100 million at Grady from the two counties for normal operations and clearly some of that goes to pay for debt service. Hopefully over time with health reform much of those resources can be shifted to resources that are tied to patients who have some form of coverage. But it is clear that not all of those are going to be able to be shifted, and it is clear that many of the services Grady provides are going to be essential to their entire community.

Grady is an entire health system, not just a hospital. It runs the emergency medical system, it runs a number of health centers, satellite hospitals and clinics. But on the other hand, Grady's renovation can be financed without a lot of up front capital from the Federal Government or from the citizens of the county.

We have a piece of legislation that we have worked closely with the community health centers and the rural health association that Chairman Stark is the primary sponsor of in the House a few small provisions of which have been included in the Health Security Act.

We urge you to look at that. We think that for \$1 to \$2 billion a year you can meet all the infrastructure needs through leveraging these dollars, through loan guarantees and interest subsidies so that a lot of this capital can be acquired in the private markets.

Mr. LEWIS. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Bernstein, prior to coming to the Ways and Means Committee, I was on the Budget Committee and we fought hard to just get language included in the budget report, begging the Ways and Means Committee to assist in leveling the reimbursement rates between rural and urban hospitals. So I am a supporter of rural hospitals. I support the incentives that you included in your testimony.

Having said that, though, there are a lot of rural hospitals that have gone out of business already because they couldn't generate enough revenue to pay their expenses, and there are more that are on the verge of going out of business. Where do we draw the line, or should we, between letting market forces have their will and running a rural hospital out of business and interjecting government aid, government support to keep that facility alive?

Are there some places in rural America that simply shouldn't support what I will call a full service hospital, but perhaps could support something less than that? And if so, are there any changes in Federal law that would help to accomplish that?

Mr. BERNSTEIN. Wow——

Mr. McCRERY. You may not be able to fully answer that question.

Mr. BERNSTEIN. I can't answer the last part, but I think I can answer the rest of it. Each State—in North Carolina, and we are getting together tomorrow for this week—first of all, a lot of hospitals probably need to—not a lot, but there are a number of hospitals that need to get out of the acute care business, and it is just a change in how medical care is delivered over time, and somehow we are just going to have to figure a way to deal with it.

I don't think that the supply and demand method of dealing with that is fair or appropriate for certain parts of rural America. So by necessity we are going to have to have some sort of planned way of supporting some hospitals that need to be in the acute care business to some extent and then adding more incentives like the EACH program which needs to be tuned up some to entice hospitals to move quicker out of inpatient care into out patient care. I think it can be done. A lot of States are trying different ways. We are developing our own way in North Carolina.

The legislation you are talking about, the problem with getting them to move that way is the reimbursement system that we have now with part A, part B, the Medicaid system, the whole thing doesn't lend itself to get hospital boards to make the move, because they don't see a funding source for the outpatient care or the emergency care that they need if they give up their inpatient care. We need to rethink that. That is what the EACH program is trying to do, and that concept needs to be refined.

Mr. McCRERY. Thank you.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Mr. Gage, I always try and understand how things would work and I understand that your organization has endorsed the President's plan; is that correct?

Mr. GAGE. We have endorsed the general principles and the key provisions of the President's plan, yes.

Mr. McDERMOTT. Because I have worked at some of these hospitals, I try and figure out how it would actually work and I would like to know your vision of how Cook County Hospital will be involved with managed care plans would it be Prudential that would want to contract with them or Cigna or Humana—how do you actually see it working, the Alameda County Hospital in his district or Harbor View in mine, or Cook County where I used to work—how do those hospitals get integrated? Who wants to take the people that usually come to them?

Mr. GAGE. Well, we have actually taken a hard look at that question. In fact as the chairman was asking Dr. Lee earlier, we are actually taking a stab at quantifying it in a way that can let us look at different scenarios for a hospital like Harbor View or Cook County that may lose half of its uninsured population but retain half the population as insured patients.

There are many different answers, depending on a variety of factors. Cook County Hospital needs to be renovated or rebuilt in a new site. It is hard to imagine Cook County Hospital in its current configuration competing very effectively except in areas like trauma care and burn care and neonatal and other services where they in fact provide the services to the entire community and not just to the poor. The fact is, we think there are provisions in the President's bill which we believe are inadequately funded and articulated, but with some help from this committee could well provide the access to the capital needed to rebuild the Cook County health system in its current—in a new configuration that would make them not just a key player for Prudential and others, but would make them an essential component for many years to come.

Cook County has what a lot of hospital and health systems lack in Chicago and elsewhere. It has a fully integrated medical staff that is largely on salary, medical departments that talk to each other about patients that share information. The information systems may need upgrading, but there is a strong commitment to low-income patients who are going to still be low-income patients even after they have a little insurance card to wave around.

We speak many different languages that are spoken at cook county but not at other hospitals. So we think there are strong reasons why hospitals like Cook County with adequate assistance will be able to compete effectively. Harbor View is an example of a hospital that probably is miles ahead of Cook County right now because of its location, its role in the community, the fact that it has been involved in a major way in managed care. But it too has those benefits. I understand your question was how under the Clinton plan versus some other plan. It was not an easy decision to come out and let people say we endorse the Clinton plan.

We see the Clinton plan as being on one side of a very clear fence that has been erected by a lot of players that we have no control over. We see your bill on one side of the fence too. Nothing would make us happier than to see a merger of the concepts. We felt we had to declare in favor of universal and mandatory coverage because if we don't honor those key principles, we don't think we will get anything and Cook County and Harbor View will be in a worse situation than they are today. We believe the Health Security Act needs a lot of amending before it can guarantee that Cook County Hospital can be a player on a level playing field under health reform, but we think the foundation is clearly there.

Mr. McDERMOTT. If I could pursue for a second—it sounds like your vision is that Cook County or whatever big city hospital would become a health network. They would market themselves and be a certified health plan under the President's proposal, that they would take those folks who live in the neighborhood, since they have been always gone there, they would just keep coming there and that would be the certified health plan for that area?

Mr. GAGE. I think survival of any system or institution is going to be based in part on developing their own networks, and in part on being able to participate in the networks and the plans of others. I don't see an institution the size of Cook County which by the way is already a major network, it is not just a single hospital sitting there on its site—it has satellite hospitals, arrangements with many health facilities and clinics. They have been talking for several years about merging the city's clinic system with the county. They are entering into an affiliation with Rush Presbyterian that would not have been thinkable 5 years ago but now makes a great deal of sense.

Cook County is going to position itself to be part of a larger system that will compete effectively, probably will and should develop plans of its own, and will also compete an a provider in the plans of others.

Mr. McDERMOTT. One of the things that it seems to me happens in the President's plan is that if a plan is full they can say we have all that we want and then the alliance can direct people to some other place. It looks to me like that the big city hospital with its health net will be the kind of receptacle for those people who aren't quick and fast enough to join other health plans and will really become I won't say a poor people's system, but a system of those who aren't quick on the draw.

Mr. GAGE. I am not even sure it is so much the patients who will be quick on the draw as it will be plans. We share the concern that has been expressed here today about what will happen when certain health plans that may not even exist today grow up to compete in Chicago or Seattle or Denver or Los Angeles and they are looking only for healthy patients who aren't going to utilize services or maybe at the other end of the spectrum the homeless and the deinstitutionalized mentally ill who they will sign up who will never go to Cook County Hospital no matter how much educating you do. We do have concerns.

However, we serve all of those patients now and we are not going to turn away patients just because they are sicker. We do believe that there are going to need to be risk adjustment factors and enabling services and other things, payments to these hospitals that will enable them to care for these patients, and we do hope that there will be also protections as discussed earlier, including civil rights protections that can be brought both by patients and by governmental entities against plans that engage in dumping and other kinds of activities, redlining, cream skinning, whatever you want to call it. We have concerns about that.

We also believe by the same token that the Harbor Views and Cook Counties will be able to compete effectively for patients they don't now have, because we think they will position themselves in most cases in networks that are going to be attractive to those patients.

Mr. McDERMOTT. It will be a surprise to me if anybody wants them in their network services except for selected services. In Seattle if you have a burn the only place to go is Harbor View. I can see why people would make those kinds of arrangements, but I can't see them making those arrangements for obstetrical, and general surgery and those sorts of things. I don't see why anybody

would contract with them to bring them into the net. That is why I think they are going to wind up upsetting their own. Thank you, Mr. Chairman.

Chairman STARK. I was curious about that myself. Am I reading that your endorsement is that you are afraid if we don't have the President's plan we won't have anything or are you saying of the plans you are aware of including Mr. McDermott's, you think it is the best? There is a difference there.

Mr. GAGE. There is a third statement to be made which is looking at the universe of plans that perhaps are going to serve as the realistic and politically acceptable basis for final passage, and I understand that Mr. McDermott's plan probably still has the largest number of house cosponsors of any plan.

Chairman STARK. You can write him off.

Mr. GAGE. I am not writing him off.

Chairman STARK. You wrote me off too.

Mr. GAGE. We just think—put it this way. The President's plan is as far to the right as we are willing and prepared to go, and yet we can see the potential for compromise on the right not just the right hand side of this committee but of the many other committees that are going to be looking at this legislation. That was really what under—

Chairman STARK. It is pretty hard to get much further to the right and still have a plan.

Mr. GAGE. I think that is probably a decision we made. To be honest with you, we are very concerned about what we hear from business groups and others who are rejecting what we consider to be genuine health reform and may leave us worse off than before—

Chairman STARK. But none of those business groups give you guys 10 cents anyway. Even Kaiser doesn't give 10 cents to Highland Hospital, and wouldn't. They are not a bad plan, but they haven't done anything for the poor or disproportionate share population in our area. They have been cherry picking for 50 years which is why they could do quite well. They are nice guys, but they are not exactly the County Welfare Department. I guess that is a concern.

I want to go back to Sara's issue on some of these cost sharing and/or ventures for people into new plans. We have had some experience in California with contracting out medical, Medicaid, only to find that people wake up and they can't go to their community health clinic any more and they really are devastated. You and I might say there is another hospital down the street; we will go there.

But I have a hunch that much of the census of these clinics are there because of language barriers or initially cultural barriers that led them to be very timid about getting in there in the first place, and after they reach a level of comfort, to have that removed seems to me to take them out of the system.

Now, this may not be a large part of America, but a large part of America, 70 percent, already have good plans. They are like us. They have Blue Cross and all these generous plans. They are good plans today, but they aren't going to Cook County Hospital or to Highland either.

If you have Blue Cross, you sure won't go near those places. First of all, they are full of poor people who don't have any insurance. Why wait in the line? You can go down the street to Alamades, which is half empty, and they will give you champagne while you wait and Blue Cross will pay for it. Those folks are OK. They are going to be in trouble if their employer quits footing the bill, and I think the President rightly perceives that.

Sara, let's talk a little more about this concept that is subtle of the payments, the copayments, or having to participate in a plan that requires going someplace to sign up and how that will, in effect—and I am not talking about some a sophisticated gatekeeper here. I am just talking about a well meaning bunch of white, middle-aged suburbanites on both sides of the aisle who decide we are going to go help poor people, who we have not had much contact with for a great number of years.

What are we doing to them if we pass the President's bill?

Ms. ROSENBAUM. If you look at basic economics of any family, a family can probably afford to spend anywhere from 5 to 10 percent of its disposal income on health care, that amount and no more. And you would have to factor in premiums, deductibles, coinsurance, and uncovered costs that would be part of the—

Chairman STARK. Drugs?

Ms. ROSENBAUM. Anything, and including a lot of services that may be health related. For example, if you have a child with asthma and have to get an air-conditioner, if you have to adapt your home in some way, if you have a child in special education who needs a related service of some kind. All of those are health expenditures, people really don't have very much disposal income for health care.

Based on some preliminary review of the various plans now under consideration, that there are two proposals on the table that certainly keep within some realistic framework the amount of money that an average family would have to pay in premium costs, and that is Congressman McDermott's bill and the President's bill. If you look at low and moderate income working families, under the President's bill, because of a lot of the health insurance costs are underwritten by employers, there is a financing source and the premium payments are reasonable. Of course, the cost sharing is higher than under the McDermott bill, which has none. By definition, the President's bill has higher cost sharing. But for a health insurance plan for an average family, it is certainly within reason.

The other bills that do not keep the spending levels reasonable at all for an average family. A lot of attention has been focused on business and government exposure. Last week when the Governors were in town, when big business was in town, we heard a lot about the burdens that they would have to bear. But during that whole week, of course, we lost any focus on the burdens that families would have to bear.

And if you assume that financing health care is a three-way proposition in the United States, among business, government, and individuals, which it seems to be under many different plans, then this whole third player was completely absent for 8 days. And that third player does very poorly when there is no assured financing source, whether it is Government payments directly, as under the

McDermott bill, or whether it is an employer premium, as under the President's bill, or a combination of the two.

Somebody has to pay for it, and if nobody comes up to the bar and pays for it, then we are left, as John Silva mentioned, with plans that purport to assure access to services and access to the coverage, but are completely unrealistic for a family that can maybe afford to pay, if it is a minimum wage working family, maybe \$20 or \$30 a month at best, toward the cost of a premium and even that is ridiculous, and certainly almost nothing in out-of-pocket copayments and deductibles.

So I guess from my time with families, I have been mystified by a lot of the discussion about universal access. I don't really care if you call it voluntary or mandatory. You can call it whatever you want. If a family can't afford it, it can't afford it.

Now, I think that too much time is being spent on the ultimate test without filling in everything that comes before. This is all an issue about who is going to bear the burden for paying for this and how those burdens will be allocated.

If I were designing a plan for very low-income people, I would charge them no premiums, nothing at the point at which they actually had to enroll in a plan and that would keep them from enrolling in a plan. No matter what you do to punish low-income people for not enrolling, they won't enroll. And I would use cost sharing very selectively.

There is some literature that suggests if you give people a health care home that they like, that you certainly can tell them, yes, you can go to an emergency room but you better be sure that that is what you need and that you haven't gone to your health care home first.

Mr. THOMAS. Excuse me. On that point, do you think that even a very modest deductible or copay is a useful educational device if it doesn't raise any money or not? What is your attitude on that?

Ms. ROSENBAUM. It is an interesting question. In the area of pediatrics, which I know better than internal medicine, adult medicine, cost sharing has either a complete impact that you don't want or it has no impact. And by that, I mean at the point at which you want a child to receive a preventive service or a primary service, the effect of a copayment is horrendous.

At the point at which a child is very sick, the copayment does nothing but reduce the amount of payment that goes to the provider because nobody at that point stands between the provider and the patient.

There have been some relatively creative uses of cost sharing to encourage such cost saving measures as substitution of generic drugs, if appropriate, and one appropriate, one therapeutically equivalent, or attempts to steer people into less costly care settings. For example, if you have an emergency room and on the same hospital campus an outpatient clinic and you say if you go to the emergency room, we will charge you \$10, but if you go to the clinic, we will only charge you \$1 or \$2, that is realistic.

Anything beyond that, I think, is either punitive to the patient or it is just a way of reducing outlays to the providers. If you want to reduce outlays to the providers, there are probably more equitable means of achieving that goal than cost sharing.

So, you know, you can't load cost sharing on people who have no money to pay for health care.

Chairman STARK. Or much else.

Ms. ROSENBAUM. Or much else. And so you have got to be realistic about what you expect people to pay. If you expect them to pay, you have to get it out of them in a way that they will be able to budget and plan for, so that they don't have to come up with it at the point of the service.

Now, that is one of the great strengths of programs like community health centers. That is one of the reasons to find health departments, community health centers. If we decide that we can't afford to reduce cost sharing within the insuring mechanism, then the great value of publicly financed health programs is that in communities where there are lots of poor people, you can target grant-based programs so that for the uncovered services, they can get those services on a sliding fee scale.

I am a great believer in the fact that health insurance is only one way to pay for care. I think we spend too much time in the United States on health insurance as the exclusive means to pay for care; one area of compromise is to combine the two in high poverty communities.

Chairman STARK. Thank you. Thank you very much. If there are no other inquiries, I will thank the panel for their participation and ask them to stay close, because as this exercise gets going in the next month or so, we are going to need a lot of help.

Thank you very much.

Chairman STARK. Our final panel will be led off by our former colleague on this subcommittee, Hon. Jim Moody, who is here in his new capacity as a visiting professor at the Wisconsin Medical College. I presume you are a professor at the Wisconsin Medical College and you are visiting us. Perhaps it is the other way around.

Mr. John Vice, who is president of Children's Hospital in Wisconsin, representing the National Association of Children's Hospitals and Related Institutions. Dr. Barbara Staggars, who is the director of adolescent medicine at Children's Hospital in Oakland, Calif., representing the California Children's Hospital Association, accompanied by Susan Maddox, who is president and CEO of the association; Martin Goldsmith, president and CEO of Albert Einstein Medical Center, in Philadelphia, representing the National Association of Urban Critical Access Hospitals; and Hon. Edward McNamara, the county executive of Wayne County, Mich., I presume representing Wayne County, Mich.

Welcome to this subcommittee. Jim, why don't you lead off with your statement?

STATEMENT OF HON. JIM MOODY, VISITING PROFESSOR, HEALTH POLICY INSTITUTE, MEDICAL COLLEGE OF WISCONSIN, MILWAUKEE, WIS.

Mr. MOODY. Thank you, Mr. Chairman, and former colleagues. It is delightful to be back here among you and to be in this hallowed room where I spent so many long hours on the other side of the red light bulb.

I wanted to make several points about the inner city and its health needs based on my 10 years representing a district that in-

cluded an inner city and my study since leaving the Congress on the issues that they face.

At first glance and taken as a whole, Wisconsin appears as a state to be in good shape, almost a prototype of state for the Clinton health care plan to succeed in, well-known for good government, hard working and compassionate people imbued with standard middle class values. We are at the top or near the top among States in education, very low in poverty. Only 8.2 percent of population have no health insurance, which is virtually half of the Nation's number. On unemployment, we continue to be one of the lowest states in the Nation. On the surface, all looks well.

Chairman STARK. Just don't drink the water.

Mr. MOODY. Pardon me?

Chairman STARK. Don't drink the water.

Mr. MOODY. Don't drink the water, right. In terms of health indices, we are in good shape too. But beneath this rosy surface, there are two worlds in Wisconsin—and I suspect in a number of other states—one world where these average indices apply, and another world where the numbers tell a far, far different story. These two worlds for Wisconsin are that 4.5 million people inhabit 99 percent of the State's land surface, and on the other hand, the 300,000 who inhabit its compact inner city.

In stark contrast to the rest of the state, the inner city is plagued with rising crime, soaring teenage pregnancy, grossly substandard public schools, high dropout rates, double digit unemployment, decaying housing stock and deteriorating tax base. During the past decade, about 10,000 jobs left Milwaukee City, while employment in the surrounding suburbs increased by over 7,000 jobs. In 1980, 32 percent of Milwaukee's residents jobs were in manufacturing which traditionally offers minorities and many others opportunities for family supporting jobs with benefits, usually including health insurance. But as of 1990, only 22 percent of the jobs were in manufacturing, a drop of about a third. And by the way, this dramatic shift has created legions of involuntarily retired pre-Medicare workers who have a huge stake in the retirement coverage issue in the Clinton plan.

The statistics of distress distinguish the world of Milwaukee's inner city from the rest of the state. Milwaukee leads the Nation in teenage pregnancy. Half of its African-American households are headed by women and over 80 percent of the infants born to those households are born to unmarried women. Infant mortality is 18.4 per thousand live births among Milwaukee's African-American community compared to only 7.5 among whites. Low birth weight, 12.9 among black newborns versus 4.7 for whites.

Child abuse continues to rise in Milwaukee's economically deprived neighborhoods, white and black. The percentage of nonvaccinated school children is only 4.2 Statewide, but is 9.5 in the inner city. Over half of the ninth graders in Milwaukee will not graduate. Almost half of these dropouts have a substance abuse problem. About 30,000 homeless live in Milwaukee, a third on the streets. Milwaukee has half of the AIDS population of the entire State.

So it is obvious that Milwaukee's inner city has extraordinary and compelling health needs. Compared to the suburbs and outer

regions of the city, the inner-city residents are 320 percent more likely to be treated for pregnancy complications, 370 percent more likely to face a threatened pregnancy, 200 to 800 percent more likely to be admitted for substance or alcohol abuse, and 143 percent more likely to be admitted for burns.

But in addition to these obviously lifestyle-related indices, the data shows that for illness after illness, inner-city residents are far more often hospitalized on an urgent or emergency basis, as the following examples show. Kidney, urinary tract, 32 percent more likely to be hospitalized on an emergency basis; immunity systems: 138 percent higher likelihood; nervous systems: 72 percent; eye conditions: 39; ear, nose, throat: 41 percent. The examples go on and on. Those are, in general, not lifestyle issues or issues directly related to poverty. Something much deeper is going on. And these indices have gotten worse over the last decade.

At the same time as these extra health needs for inner-city residents have been growing, city hospital capacity has been decreasing. Four city hospitals have closed or moved to the suburbs and only one remains viable. Milwaukee's county large public hospital system and a very excellent children's hospital, are at the suburb of Wauwatosa, which is some 4 or 5 miles out of downtown.

Only three private practice physicians remain in Milwaukee's inner city as a result of low Medicaid reimbursement rates, although there are four very important clinics struggling to serve about 25,000 low-income patients per year with personnel, including doctors.

Implications for the Clinton plan. The chief point I would like to make is that a health care reform plan that may work well, even very well for a State like Wisconsin as a whole and many States like it, may not work well at all for the inner city in places like Milwaukee, the other world I speak of.

The Clinton plan relies heavily on market forces to deliver health care on a high quality, reasonable cost basis to health conscious and cost conscious consumers who will make educated, informed choices between an array of plans and providers. Assuring this approach works well across the country—and I hope it does if it is passed—this does not at all assure that it will work without extensive nonmarket interventions in places like Milwaukee.

The fear that health resources for inner-city providers will be inadequate is heightened by the administration's announcement that a reform plan will cut into Medicare and medicare funding, including the disproportionate share funds for hospitals that now have a high proportion of Medicaid and Medicare patients, and into direct and indirect medical education.

But the two larger questions, it seems to me, for inner-city residents are, one, how will the essential community provider feature of the Clinton plan be actually organized? And, two, how will health alliances be structured in urban areas? The essential community provider aspect of the Clinton plan recognizes that nonmarket features must be grafted onto the plan. Hopefully, this initiative will build on and learn from the extensive experience of the community health centers and clinics which have done much in a city like Milwaukee to fill the gap created by closing and re-treating hospitals. For these existing health centers and clinics, the

key issue, of course, will be availability of resources. For example, will alliances be required to pass on to such inner-city providers the financial benefits of the so-called risk adjustment payments, or will they be able to keep them to enhance the financial strength of the alliance itself? The inner-city clinic would normally not have enough economic bargaining strength to require these transfers, absent legislative requirement.

Second, will the alliances in States like Wisconsin with cities like Milwaukee be required to risk pool inner-city residents along with large noninner-city populations? Or will the alliance be able to avoid such high-risk groups? This has been discussed in earlier panels and I won't dwell on it here. Obviously the size of the opt out requirement will also impact this. The smaller the size of the opt out, the more companies with a healthy work force will opt out, leaving behind the inner city with the high health needs and high health costs.

This leads me to my final point regarding outreach and prevention. For cities like Milwaukee, the Clinton plan must place a special emphasis and inducements on prevention, an emphasis far above what might be necessary in the rest of the State. The 1989-90 measles outbreak in the city of Milwaukee offers a glimpse of why an ordinary managed care system, such as that proposed in most health care reform plans now before Congress, might not work well in the environment of a typical inner city. Over 70 percent of the 1,000 Milwaukee children struck by measles in late 1989 and early 1990—of which 260 had to be hospitalized and 3 died—were in fact enrolled in HMO-type managed care programs funded by Medicaid. It also turns out that two-thirds of the HMO-covered children were unvaccinated even though it was clearly in the financial interest of the HMO to do so. It had not vaccinated those children.

Postcrisis analysis shows that the HMOs had totally failed to engage in the type of aggressive outreach effort to families to vaccinate their children. When the city's Public Health Department finally stepped in, over 11,000 children were quickly vaccinated under a city-run program of public information and outreach, which included family involvement and support.

The measles incident is not an indictment of HMOs or managed care in general, but it shows that it can likely—very likely to be necessary to, one, bridge the knowledge and communication gaps that exist in economically distressed communities, and two, bring publicly provided health resources to supplement those induced by market forces alone.

In summary, I would say the Clinton health reform blueprint promises to fundamentally alter the coverage, the cost and the fairness of the American health care system. But beneath the surface of glossy averages, there are pockets of disadvantaged population in our country, especially in our inner cities, which will need two things: One, targeted resources far beyond those created by market forces or managed competition, and two, policy adjustments to the proposed legislation if these disadvantaged groups are to share in the promise of dramatic improvement.

[The prepared statement follows:]

TESTIMONY OF JIM MOODY
MEDICAL COLLEGE OF WISCONSIN

Wisconsin, the "Model" State

At first glance, and taken as a whole, Wisconsin appears in good shape, almost a proto-type state for the Clinton plan to succeed in. It is well known to be a hard-working, good-government, compassionate state imbued with standard middle class values. At or near the top in education scores, fourth lowest in incidence of poverty, etc. Only 8.2% of its population has no health insurance -- nearly half the national proportion. Wisconsin's state wide unemployment is one of the lowest in the nation.

In terms of health indices, Wisconsin as a whole also does well: 3rd lowest in measles and other vaccine-preventable disease, 2nd lowest in drug and alcohol abuse related hospital admissions, etc.

Two Worlds

But beneath this rosy surface, there are two worlds -- the world where these average indices apply and another world where the numbers tell a far, far different story. These two worlds are (1) the 4.5 million people who inhabit 99% of the state's land surface, and (2) the 300,000 who inhabit its compact inner city. In stark contrast to the rest of the state, the inner city is plagued with rising crime, soaring teenage pregnancy, grossly substandard public schools, high drop out rates, double digit unemployment, decaying housing stock and a deteriorating tax base.

Milwaukee contains 90% of the state's minority, and about 95% of the state's African-American population. Over 30% of the city is Black, about 6% is Hispanic and another 3.5% is Native American or other minority.

During the past decade, about 10,000 jobs left Milwaukee city, while employment in the surrounding Milwaukee suburbs increased by over 7,000. In 1980, 32% of Milwaukee residents' jobs were in manufacturing, which has traditionally offered minorities opportunities for family-supporting jobs and benefits, including health insurance. As of 1990 only 22% of the jobs were in manufacturing, a drop of about one third.

Statistics of Distress

The statistics of distress distinguish the world of Milwaukee's inner city from the rest of the state. Milwaukee leads the nation in teenage pregnancy. Half of its African American households are headed by women and over 80% of its infants are born to unmarried mothers.

Infant mortality is 18.4 per 1,000 live births among Milwaukee's African Americans, compared to only 7.5 among whites. Low birth weights is 12.9% among black newborns vs. 4.7% for whites. Child abuse continues to rise in Milwaukee's economically deprived neighborhoods. The percentages of non-vaccinated school age children is only 4.2% statewide but is 9.5% in the inner city. Over half of the 9th graders in Milwaukee will not graduate. Almost half of these dropouts have a substance abuse problem. About 30,000 homeless live in Milwaukee, a third of which live in the streets. Milwaukee has over half of the state's AID's patients.

Health Needs in the Inner City

With the economic and demographics figures cited above, it is obvious that Milwaukee's inner city has extraordinary and compelling health needs. Compared to suburban and outer regions of the city, inner city residents are:

320%	more likely to be treated for pregnancy complications,
370%	more likely to face a threatened pregnancy,
200-800%	more likely to be admitted for alcohol or substance abuse, and
143%	more likely to be admitted for burns.

But in addition to these obviously "life-style" related indices, the data show that for illness after illness, inner city residents are far more likely to be hospitalized on an urgent or emergency basis. The following examples show these increased percentages:

Kidney/urinary tract	32%
Blood/immunity system	138%
Nervous system	72%
Eye condition	39%
Ear/nose/throat	41%
Respiratory system	39%
Circulatory system	63%
Digestive system	29%
Hepatobiliary system	51%
Musculoskeletal system	21%
Skin/subcutaneous tissue/breast	97%
Infectious parasitic disease	53%

These indices have gotten steadily worse over the decade. At the same time as these extra health needs for inner city residents have been growing, city hospital capacity has been decreasing. Four city hospitals have closed or moved to the suburbs, and only one downtown hospital, Sinai Samaritan remains viable. Milwaukee County's large public hospital whose emergency room serves as family medicine provider for thousands of inner city residents, is located in the suburb of Wauwatosa about five miles from downtown. Only three private-practice physicians remain in Milwaukee's inner city, although there are four public clinics struggling to serve about 25,000 low income patients per year with a variety of

personnel, including some physicians.

Implications for the Clinton Plan

The chief point I would like to make is that a health reform plan that may work well -- even very well -- for Wisconsin as a whole, and many states like it, may not work well at all for an inner city like Milwaukee's. The Clinton plan relies heavily on market forces to deliver health care on a high quality, reasonable cost basis to health-conscious and cost-conscious consumers who will make informed choices between an array of plans and providers. Assuming this works well across the country -- and I hope it does -- it does not assure that without extensive, non-market intervention there will be adequate and appropriate provision of health services to the inner city, and a meaningful range of choices placed before its residents.

The fear that health resources for inner city providers will be inadequate is heightened by the Administration's announcement that the reform plan will cut into Medicare and Medicaid funding, including the "disproportionate share" funds for hospitals that now have a high proportion of Medicaid/Medicare patients into direct and indirect medical education funding for teaching hospitals, most of which have a high proportion of inner city patients.

But the two larger questions for inner city residents are:

- (1) How will the "Essential Community Provider" feature of the Clinton plan be organized?
- (2) How will the Health Alliances be structured in urban areas?

The Essential Community Provider aspect of the Clinton plan recognizes that non-market features must be grafted onto the plan.

Hopefully, this initiative will build on and learn from the extensive experience of the community health center and clinics which

have done much in cities like Milwaukee to fill the gap created by closing and retreating hospitals. For these existing health centers and clinics, the key issue, of course, centers around availability of resources. For example, will Alliances be required to pass on to such inner city providers the financial benefits of the "risk adjustment" payments, or will they be able to keep them to enhance the financial strength of the Alliance itself?

The inner city clinics would normally not have enough economic bargaining strength to require these transfers.

Will Alliances in states like Wisconsin with cities like Milwaukee be required to risk pool inner city residents along with large non-inner city populations, or will Alliances be able to avoid such high-risk groups? The fractions here are important. If one Wisconsin Alliance is required to cover all 300,000 inner city inhabitants, obviously its cost structure will be very different than if it covers, say, only one tenth of them, with nine other alliances dividing up the rest.

The Crucial role of Prevention Outreach

The final point I would make is that for cities like Milwaukee, the Clinton plan must place special emphasis and inducements on prevention - emphasis far above what might be necessary in the rest of the state. The 1989-90 measles outbreak in Milwaukee offers a glimpse of why an ordinary managed care system, such as proposed in most health reform plans now before Congress, may not work well in the environment of a typical inner city. Over 70% of the 1,000 Milwaukee children struck by measles in late 1989 -- of which 260 had to be hospitalized and three died -- were in fact enrolled in an HMO type managed care program funded by Medicaid. Two thirds of the HMO covered children turned out to be unvaccinated, even though it was clearly in the HMO's financial interest to do so. Post-crisis analysis showed that the HMO's had totally failed to engage in the type of

aggressive outreach effort to families to vaccinate their children. When the city's public health department finally stepped in, over 11,000 children were quickly vaccinated under a city-run program of public information and outreach which included family involvement and support.

The measles incident was not an indictment of HMO's or managed care but it shows that it can be necessary to (1) bridge the knowledge and communication gaps that exist in economically distressed communities, and (2) bring publically provided health resources to supplement those induced by market forces alone.

The Clinton health reform blueprint promises to fundamentally alter the coverage, cost and fairness of the American health system. But beneath the surface of glossy averages, there are pockets of disadvantaged population in our country, especially in our inner cities, which will need targetted resources beyond those created by market forces of managed competition and some policy adjustments to the proposed legislation, if these disadvantaged groups are to share in the promise of dramatic improvement.

Chairman STARK. Mr. Vice.

STATEMENT OF JON E. VICE, PRESIDENT, CHILDREN'S HOSPITAL OF WISCONSIN, MILWAUKEE, WIS., ON BEHALF OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC.

Mr. VICE. Mr. Chairman, I am Jon Vice, President of Children's Hospital in Wisconsin. Thank you for the opportunity to testify for NACHRI, which stands for the National Association of Children's Hospitals and Related Institutions.

Children's hospitals are located in metropolitan areas, meeting the primary as well as specialty care needs of children in the inner city. They are central providers of care to the poorest children. They are regional referral centers for children with special care needs, centers of pediatric medical education and centers of child health research.

Consider our hospital. We are an essential provider for the poorest children. Although there are 24 hospitals in the Milwaukee area, we care for 86 percent of all hospitalized children. We devote nearly half of our care to children covered by Medicaid, despite the fact that we incur annual payment shortfalls in the millions of dollars. Children's Hospital is a regional referral center. We have the State's only level one pediatric trauma care unit. Our pediatric intensive care unit is filled to capacity. We serve children with highly specialized care needs from both the inner-city and remote rural areas.

Consider this: Less than 8 percent of all of our patients account for more than half of our revenues because they require such extraordinary care. Our hospital is also a center of pediatric medical education and research. More than 70 percent of the pediatricians practicing in the State and more than 75 percent of the pediatric nurses receive their training at Children's Hospital. Because of that fact, medical education accounts for 9 percent of our costs.

Health care reform has been a major issue for several years, but recently public leaders have begun to ask whether there is a health care crisis. We think the bottom line is the fact that more than 1 in 3 children now are uninsured or rely on Medicaid. Because these children's numbers are growing, their need and their parents' need for universal coverage are growing, too. Many in the Congress and the President want to build reform on the commercial managed care market. Whether it is managed competition or incremental reform, many proposals will result in more children being enrolled in managed care.

Children's Hospital has quite a bit of experience with managed care. The majority of our patients today are in managed care. We established and ran a capitated managed care plan with 30,000 Medicaid enrollees. We believe the principle of managed care, creating incentives that reward access to timely, appropriate and cost-effective care has great potential for children. But we also know from experience that managed care's potential is not easily realized when cost reduction is the primary goal and the system is not designed, implemented and monitored for children.

When managed care becomes only managed pricing, there are no incentives to pay for the cost of treating the poorest patients or the

sickest patients or training the next generation of providers. In that kind of market, the children's hospital with a mission of clinical care, education and research, will be forced to make difficult choices, give up its underfinanced care or fail to compete, give up its care for the most difficult cases or fail to compete, give up its responsibility to train the next generation of pediatric providers or fail to compete.

Associations like to talk in slogans, and NACHRI is no different. In health care reform, we need to manage the competition so kids win too. Based on our experience serving children in Milwaukee's inner city as well as our State's most remote rural areas, that slogan translates into several specific proposals.

First, NACHRI recommends that reform recognize the role of essential community providers that serve children, based on service to the underserved population, not on geographic location. Reform should designate not only publicly funded primary care clinics, but also public hospitals and children's hospitals devoted to the medically underserved. Plans should contract with essential providers and negotiate payment adequate to the cost of care.

Second, NACHRI recommends reform should change the way we finance medical education. Since managed care plans don't have incentives to pay for the cost of medical education, all payers should contribute to the cost.

Third, NACHRI recommends that reform should recognize the role of designated centers of excellence to meet children's needs. They need to be part of every health plan and enrolled children need to be assured they will get access to sub specialists trained to care for children, not adults.

Finally, NACHRI recommends that reform should explicitly address children with special care needs. They represent less than 5 percent of all children. They will get lost in the statistical margins of error if benefits, provider networks, financing and public accountability don't fit them. Even after a decade of experience, our State Medicaid program still does not enroll certain children with special needs, such as a child with AIDS or the child who is mentally dependent in managed care because HMOs know how expensive they are.

Mr. Chairman, that concludes my remarks. I would be glad to answer any questions you might have.

Chairman STARK. Thank you, Mr. Vice.

[The prepared statement follows:]

Written Remarks

Mr. Chairman, I am Jon E. Vice, President of Children's Hospital of Wisconsin of Milwaukee, WI.

I am also a former chairman of the Board of Trustees of NACHRI -- the National Association of Children's Hospitals and Related Institutions. On behalf of NACHRI, which I represent today, I want to thank you very much for the opportunity to testify before your subcommittee regarding health care reform and children of the inner city and rural areas.

NACHRI represents more than 130 institutions in the United States and Canada, including free-standing acute care children's hospitals such as my own, pediatric departments of major medical centers, and specialty children's hospitals devoted to specific services such as rehabilitative care for children.

Children's Hospitals in the United States

Children's hospitals are driven by missions that commit them to serving all of the children of their communities, including the sickest, poorest, and those in need of the most specialized care, through the delivery of primary and subspecialty care in both inpatient units and outpatient clinics. Children's hospitals also are driven by missions that commit them to serving the children of tomorrow through medical education training the next generation of pediatric health care professionals and research advancing the base of knowledge and the state of the art of children's health care. For example:

- Essential Provider to Low Income Children Virtually all children's hospitals are non-profit and located in major metropolitan areas, meeting the primary as well as the specialty care needs of the children of the inner city, especially the children of the lowest income inner city neighborhoods. On average, children's hospitals devote nearly 50 percent of their care to children who depend on Medicaid or are uninsured.
- Specialized Regional Referral Centers Children's hospitals also are regional referral centers, meeting the specialized care needs of children from the most distant rural areas as well as the the closest inner city neighborhoods. On average, a children's hospital devotes more than 70 percent of their care to children with chronic or congenital conditions. Freestanding children's hospitals represent only one percent of all hospitals, but they care for 25 percent of all hospitalized children with chronic or congenital conditions and the majority of children with specific specialized care needs. Children's hospitals and the pediatric departments of university medical centers together represent only seven percent of hospitals, but they care for the vast majority of children with specialized care needs.
- Centers of Pediatric Medical Education Although they represent only one percent of the nation's hospitals, free-standing children's hospitals train a quarter of all pediatricians. Together with pediatric departments of major university medical centers they train the majority of pediatricians and virtually all pediatric subspecialists in the United States.
- Centers of Child Health Research More than one in three children's hospitals is the formal sponsor of research on the cause, prevention, and treatment of illness in children. Many more participate in research through universities with which they are affiliated. For example, it was a children's hospital which first identified AIDS in children, and it was a children's hospital that first cultured the polio and measles viruses.

Children's Hospital of Wisconsin

Children's Hospital of Wisconsin is a 222 bed private, independent, not-for-profit pediatric medical center. It is typical of the nation's children's hospitals. For example:

- Essential Provider to Low Income Children There are 24 hospitals in the metropolitan Milwaukee area, but one hospital, Children's Hospital of Wisconsin, hospitalizes 86 percent of all children, including children from every zip code except one in the city. We devote about half of the care we provide to children who depend on Medicaid to pay for their health care, either directly or through their enrollment in managed care plans. We serve children not only through inpatient services but also through extensive outpatient clinics, including primary and urgent care clinics in inner city neighborhoods. We provide care in more than 65,000 emergency room and urgent care visits and more than 100,000 outpatient clinic visits each year.
- Specialized Regional Referral Center Children's Hospital of Wisconsin is the only level one regional pediatric trauma center in the State of Wisconsin. Our pediatric intensive care unit regularly operates at more than 90 percent capacity. In addition, our hospital serves children with specialized care needs from throughout the region, including children with cancer, malfunctioning hearts, cerebral palsy, AIDS, and many other conditions. These are children who require very specialized care not only when they are very sick but also when they just need basic primary and preventive care.
- Center of Pediatric Medical Education Through its affiliation with the Medical College of Wisconsin, Children's Hospital of Wisconsin is a major center of pediatric medical education. Approximately 70 percent of all pediatricians practicing in the State of Wisconsin trained at our hospital. And all family practice residents affiliated with the Medical College of Wisconsin receive the pediatric portion of their residency training at our hospital. Through our affiliation with nine nursing schools, more than 75 percent of all nurses trained in pediatrics in Wisconsin received their training at Children's Hospital of Wisconsin.
- Center of Child Health Research Children's Hospital of Wisconsin conducts pediatric research through our affiliation with the Medical College of Wisconsin, whose chairman of the Department of Pediatrics is our Physician-in-Chief. We have specialized in research related to blood disorders, unrelated bone marrow transplants, and pain management. Children's Hospital of Wisconsin also is a growing center of pediatric nursing research.

In addition to all of the above, Children's Hospital of Wisconsin is plays important roles as a partner in public health promotion with the City of Milwaukee and as an advocate of children. We have joined with Milwaukee's Public Health Department in a multi-year campaign to improve immunizations rates dramatically. We are engaged in a prenatal care education program targeted at high risk women. We administer a multi-year grant program to assist clinics not run by the hospital to serve uninsured and underinsured children in the inner city. We speak out and address issues affecting children's health, education, safety, and security in our community. For example, in response to dramatic increases in the numbers of children injured and killed by firearms, Children's Hospital of Wisconsin has become a leading champion of firearms control, including a ban on all handguns.

In speaking about health care reform, NACHRI and its member hospitals have sought to make two basic points:

- First, children's hospitals believe children especially need health care reform that guarantees universal coverage, because children often are the first to be hurt by the continued erosion in private health care coverage and rapid changes in the health care marketplace.
- The second point children's hospitals make on health care reform is this: We believe that all reform must be tailored to fit children's needs, and reform specifically based on competition must be managed so kids win, too.

I will elaborate on these two points later in my statement, but for the purpose of the panel discussion, I would like to focus my oral remarks on NACHRI's specific recommendations that relate to children of inner city and rural communities. These children depend not only on the community and other public funded health centers serving the medically underserved, but also on institutions such as children's hospitals with missions of serving low income children, serving children with special care needs, training future health care providers, and advancing health care research.

Based on this, NACHRI offers four sets of core recommendations.

- 1) First, health care reform should recognize the role of the "essential community provider." These are the publicly financed providers upon whom people living in medically underserved inner city and rural areas depend for care, because the commercial marketplace does not meet their needs.

NACHRI recommends that health care reform legislation designate not only publicly financed primary care clinics but also public hospitals and children's hospitals serving a disproportionate share of low income patients as "essential community providers." Health plans should be required to contract with essential community providers, to cover the care given to people living in medically underserved areas, and to negotiate payment rates that meet at least minimum standards.

- 2) Second, health care reform should recognize the need to separate the financing of graduate medical education from patient care reimbursement.

NACHRI recommends that all payers should be required to finance the direct and indirect costs of graduate medical education. Within federal guidelines, the total number, division among subspecialty care, and allocation of residencies should be determined by health care professionals independent of the political process. This is especially important if national policy on GME is to recognize how different pediatric medical education is, with 85 percent of all pediatricians already practicing primary care, and the need for our health care system to train both more general practice and subspecialty pediatricians. Finally, funding for graduate medical education should be allocated to the teaching institutions that incur the direct costs of GME and the indirect costs of being academic health centers.

- 3) Third, health care reform should recognize the role of "centers of excellence" and specialized centers of care established to meet the needs of children.

NACHRI recommends that health care reform ensure children's access to designated pediatric centers of excellence through their inclusion in health plans and the ability of enrolled children to receive care from them.

- 4) Fourth, health care reform should explicitly and coherently address the needs of children with specialized care needs.

NACHRI recommends that reform establish a process for defining children with special care needs, define standard benefits tailored to fit their needs, require plans to offer parents the ability to receive care from appropriate pediatric subspecialists for the care of these children, and establish measures of cost, quality, outcomes, and consumer satisfaction that are specific to their needs. Precisely because children with special care needs represent less than five percent of all children, special focus must be given to their needs in health care reform. Otherwise, they will be lost to statistical margins of error in any evaluation of reform.

These four recommendations are by no means the limits of the issues that should be addressed to meet children's health care reform needs. But from the perspective of children's hospitals, it is imperative that reform recognize clearly the roles of essential providers, teaching institutions, and centers of excellence for children, and establish a clear focus on children with special needs.

Mr. Chairman, in the balance of my written testimony I would like to expand upon NACHRI's views on health care reform and its implications for children.

Children Need Universal Coverage

Children in particular need reform that guarantees universal coverage, because they are often the first to be hurt in the continued erosion in commercial health care coverage. Studies show that in the struggle to cope with rising health insurance costs, both employers and individuals often draw the line first at paying for dependent coverage. Loss of dependent coverage, as well as pre-existing condition exclusions and life-time maximums on coverage, hit children hard, especially those requiring the care of a children's hospital.

As a consequence, more than one in three children in the United States now depends either on Medicaid, which is a critical but often underfinanced poverty program, or is uninsured. That proportion continues to grow. In 1992, 13.5 million children under age 18 depended upon Medicaid and another 9.5 million children were uninsured, representing 35 percent of the nation's 65.1 million children, according to estimates based on U.S. Census Bureau survey data.

Medicaid has become the nation's safety net for children's access to health care -- particularly children with special care needs. The emergence of Medicaid as children's health care safety net has been a tremendously important development. But we know that Medicaid often has been challenged to fulfill its promise to children because of inadequate resources for eligibility, outreach, and payment. We also know that many states are now stretched to the financial limit by their Medicaid programs. In today's fiscal and political climate, Medicaid and charity are an imperfect and ultimately financially unsustainable safety net for children.

Children also are at the frontlines of change in the health care delivery market place, and the pace of that change is about to step up substantially because of Medicaid. In health care marketplaces around the country, we are seeing a significant surge in the conversion of traditional indemnity coverage for fee-for-service health care into managed care coverage, including enrollment in risk-bearing, capitated health plans.

Many state Medicaid programs are contemplating what the State of Tennessee has received federal permission to do -- enrollment of all Medicaid recipients into capitated managed care plans in a matter of only months, regardless of the experience of either the state or its commercial markets with capitated managed care. Since

half of all Medicaid recipients are children, and 70 percent are mothers or children, the conversion of Medicaid fee-for-service to capitated managed care will be especially significant for children and their ability to receive the care they need.

If implemented carefully, managed care holds great potential for children by creating incentives for them to receive health services when they can benefit most from them. But make no mistake about it, the statewide Medicaid managed care experiments upon which states are embarking at times of extraordinary fiscal crises are experiments that will be undertaken primarily with children as their subjects. The issue is not managed care; it is the adequacy of time and resources to undertake these statewide experiments and the adequacy of the focus on their impact on children.

That is why we believe health care reform, based on mandated employer-financed health coverage, is so important for children, both to give all children coverage of uniform health care benefits and to influence the way in which health care is financed so that coverage translates into access to appropriate care.

Health Care Reform Should Be Tailored to Fit Children's Needs

Many Members of Congress have visited a children's hospital -- as a parent, family member, or friend of a patient or as a guest of the hospital. You know that our institutions look and feel very different from other hospitals. You know that the care givers who work with our institutions often have different training and different experience than care givers in other hospitals have.

All of these differences that define the character of a children's hospital might be summed up by the slogan: "When it comes to children, one size won't fit all. We must tailor health care to fit their needs." This slogan may have a simplistic ring to it, but it has profound implications for the way we deliver care to children. Just last summer, the Institute of Medicine highlighted this point by issuing a major report on emergency care for children. It concluded our health care delivery system fails to meet the needs of children who suffer from injury or trauma, because all too often our emergency and trauma care services are designed to fit the needs of adults or "average" people, not the needs of children.

For example, because children have smaller veins that often are not receptive to emergency injection of fluids, such injections may need to be made directly into their bone marrow. And because children's blood supply is smaller, injured children frequently experience a much faster drop in blood pressure. As a consequence of emergency services not being designed to fit these kinds of different needs, children's survival and recovery from injury or trauma suffer.

The children's hospitals believe it is equally true that when it comes to health care reform, one size won't fit all. We must tailor the requirements of reform to fit children's needs. I would like to give you examples of what I mean by focusing on four areas of bipartisan agreement on health care reform between members of both political parties. These areas of agreement involve commitments to uniform benefits, managed care, cost containment, and Medicaid's reorganization.

Uniform Benefits Members of both political parties have advocated that the federal government establish, by act of Congress or independent commission, a uniform benefit package for all Americans, with special emphasis on primary and preventive care. That is a very important, bipartisan commitment, which is sure to benefit children, for whom preventive and primary care often are the least expensive and promise the best financial returns in terms of well-being and future productivity. However, as experts in the care of children with special care needs, children's hospitals know

that it is equally important to focus attention on how the benefits will cover the needs of the child with a chronic or congenital condition, such as cerebral palsy.

For example, if they limit coverage for rehabilitation to treatment of a condition resulting from an "illness" or "injury" or related to an "acute care episode," uniform benefits could be subject to the risk of interpretation that they do not cover congenital conditions, which are not the result of illness, injury, or acute care episode. Similarly, a limit on coverage to treatment that results in "improvement" of function could deny coverage of therapies that would enable children with special needs to "maintain" a level of function, allowing them to attend school or live at home. Or it could deny coverage of therapies prior to surgery that could be essential to a successful outcome. In addition, an "improvement" standard may not recognize the need for "habilitation" to help children attain function for the first time.

That is why children's hospitals say that the uniform benefits in health reform must be tailored to fit all children, including children with special care needs who require access to ongoing specialized care, which is not the same as long term care.

Managed Care Members of both political parties believe that in order to restructure the way in which we deliver care, we need to promote more enrollment of individuals and families into risk-bearing, capitated health plans competing with one another in the marketplace. Whether they call it managed competition, managed collaboration, or something else, they believe we should give health plans an incentive to manage the care needs of individuals cost-effectively by having them compete for a single, fixed per capita payment -- adjusted for the risk associated with the individual's health needs -- for every individual enrolled.

Managed care has great promise to meet the needs of children if financial incentives facilitate their access to primary and preventive care. Indeed, through the provision of multi-disciplinary care involving the family, many children's hospitals have pioneered in managed care in the best sense of the word by trying to make sure the child receives the most appropriate care, including inpatient care, only when it is truly necessary.

But if managed care is purely cost-driven, it can have the opposite effect for children, denying them access to appropriate care instead of assuring it. The fact is that many of the protections essential to managed care -- risk adjustment, public cost reporting, measures of quality and outcomes -- have not been developed for children, in particular children with special care needs. At the same time, because so few children require hospitalization, they are much more dependent than adults on having access to regionalized centers of care. They see a large enough volume of pediatric patients with specialized conditions that they are able to achieve and maintain both expertise and efficiency in pediatric care.

Such institutions -- children's hospitals -- also carry the added costs of their commitments to serving a disproportionate share of low income patients, training the future generation of pediatric health care professionals, conducting pediatric medical research, and caring for the sickest of patients. If driven only by costs and lacking adequate tools for risk adjustment or measures of quality for children, managed care plans often will refer only the sickest and most expensive patients to children's hospitals and other pediatric specialized facilities, making them financially unsustainable. Or plans will refer children requiring specialized care to hospitals with with adult but not pediatric subspecialists. To gain competitive advantage, managed care plans will seek to prevent children's hospitals from contracting with multiple plans, which often is essential for the hospital to serve a large enough population of children to sustain its specialized services. These

are not concerns borne out of speculation; they are the real life experiences of children's hospitals seeking to fulfill their missions in competitive markets driven by managed care.

That is why children's hospitals believe it is so important that health care reform built upon capitated health plans must manage the competitive market to ensure children's access to the care they need. It is important to require that health plans:

- provide access to pediatric specialists and subspecialists, including at least one hospital that specializes in the care of children, so that when a child needs a cardiologist or pulmonologist or other subspecialist, it is one who is trained in pediatric cardiology or pediatric pulmonology or other pediatric subspecialties;
- give parents choice among providers for both primary and specialty care, including choice of specialists to deliver primary care to children with special care needs, should they demonstrate the capacity to provide such care;
- allow pediatric providers to contract with multiple plans;
- contract with and refer patients to hospitals that have demonstrated themselves to be "essential" to the children of low income and medically underserved communities;
- contract with and refer patients to recognized centers of excellence and specialization for pediatric trauma care, level III neonatal intensive care, pediatric intensive care, high risk perinatal care, and other, highly specialized services;
- separate the financing of graduate medical education from patient care reimbursement, by requiring all payors of care to contribute to a pool of funds, which are used to meet both the direct and indirect costs of graduate medical education and are paid to the institutions that incur those costs; and
- account to the public for the costs and quality of care, consumer satisfaction, and health status of the population served in terms that are specific to children and their needs.

The net effect of such public policy requirements should be to foster the development of integrated pediatric care networks, either within health plans or independent of them. An integrated pediatric care network would assemble a team of family practice physicians, pediatricians, and other primary care givers as well as pediatric subspecialists. They would have an identifiable mission of service devoted to children, expertise to meet children's needs, resources measured in terms of children's needs, and accountability for the cost, quality, outcomes, and consumer satisfaction specific to children's experience. Indeed, it may well be worth considering that health reform policy should require health plans to demonstrate to consumers that they have such integrated pediatric care networks.

Children's hospitals believe these kinds of policies will be needed to manage competition so kids win, too.

Cost Containment There has been much disagreement both between Democrats and Republicans, and within their respective parties, about whether and how to cap the growth in health care spending nationwide, the growth in commercial insurance premiums, or the amount of reimbursement given to individual providers.

However, as institutions that devote a major portion of care to children assisted by Medicaid, children's hospitals are struck by the fact that members of both political parties strongly agree on capping the growth in Medicaid, at least at a per capita level. That is the equivalent of a de facto spending cap on health care spending for children. Children's hospitals do not support the

principle of government imposed caps on health care spending, but they already live with the reality of caps on Medicaid. We believe it is imperative to talk about the need for cost containment strategies to be adjusted to fit children's needs.

Let me explain why this is so important. Children have different health care resource requirements than adults have, and the patients of children's hospitals have different resource requirements than children receiving care in general hospitals. For every hour in the hospital, a child on average requires 31 percent more routine nursing care than an adult; a child younger than two requires 45 percent more care than an adult. The patients of children's hospitals require even more intensive care, because they are younger, sicker, and more likely to have a chronic or congenital condition than the pediatric patients of general hospitals. Since nursing care is a major portion of the expense of hospitalization, these differences can have significant implications for the resource requirements of children.

Too often, strategies to cap health care spending fail to take into account these differences. We see proposals to cap either national health care spending or Medicaid based on an extrapolation of historical rates of health care expenditures, in which the costs of children's and adults' care have been averaged together. In addition, children have been disadvantaged in historical spending -- because they have been disproportionately poor, dependent upon Medicaid which has inadequately reimbursed care, and dependent upon primary and preventive care, which indemnity plans traditionally did not cover. Caps on health care spending will not make sense for children if they are based on historical spending, instead of an assessment of children's real health care needs.

Most advocates of capitated payment for health care have recognized the importance of risk adjustment -- adjustment of capitation for the risk of higher or lower costs of care associated with an individual. Without such risk adjustment, a health plan or health care provider who cares for a population that is disproportionately sicker would be at financial risk. This is exactly what a children's hospital is -- an institution which specializes in caring for higher risk children with the most complex care needs. However, experts have testified before this subcommittee that risk adjustments specific to the needs of children -- particularly children with special care needs -- do not exist, and will take years to develop. We must begin now to invest in risk adjusters for children, even before embarking on health care reform. And if reform is implemented before pediatric risk adjusters are developed, interim measures, such as mandatory reinsurance for a wide range of children's chronic and congenital conditions, or exclusion of these cases from capitation, will be necessary.

Children's hospitals have learned the necessity of adjusting cost containment strategies to children's needs through years of living with state Medicaid programs and private payors, which have adopted the Medicare diagnosis related groups (DRG) payment methodology, even though it was not designed for a pediatric population. According to financial experts whom the federal government often has used for payment policy analysis, no children's hospital could survive financially if it were subject to the Medicare payment system unadjusted for the needs of children in general and the needs of children's hospitals' patients in particular. In fact, these experts have stressed that in health reform based on competition, it is essential that the adjusters be based primarily on children's needs.

That is why children's hospitals believe that in health care reform, cost containment strategies must be tailored to fit children's needs.

Medicaid According to opinion surveys, most people think Medicaid is either a welfare program or Medicare. But to

children's hospitals, Medicaid represents the nation's largest and most important child health program. No single program, public or private, affects more children nationwide or more children in children's hospitals. Therefore, it is especially important that great care be given to how health care reform transforms Medicaid.

Let me give you an example. Many members of both political parties have called for the elimination of Medicaid disproportionate share payment adjustments -- extra payments given to hospitals that serve a disproportionate share of low income patients. They contend that such disproportionate share payments are only needed to pay for the costs of care of charity patients. With the achievement of universal coverage, they believe, such payments no longer will be necessary.

However, to children's hospitals, disproportionate share payments represent something entirely different. In many states, the Medicaid program makes disproportionate share payment adjustments because the base Medicaid payment rate is substantially inadequate to cover the costs of care. These payment adjustments have been critical to the ability of children's hospitals' ability to play such an important role in providing access to care for children of low income families.

If Medicaid financing continues at historically inadequate levels, exacerbated by the elimination of disproportionate share payments, health plans and communities with larger numbers of low income people will be particularly hard hit, as will the institutions devoted to serving them. This will be doubly true for institutions such as children's hospitals, which serve large numbers of both low income and high risk patients.

Similarly, most people are not aware that contained within Medicaid is an extremely important national health policy for children. It is a commitment, through EPSDT, that every Medicaid eligible child is entitled to medically necessary care, regardless of whether the services required to provide that care are otherwise provided by states to adults under Medicaid. Proposals that eliminate Medicaid need to preserve this commitment to medically necessary care to the most vulnerable children, so that they are not worse off as a result of national reform.

These are examples of why children's hospitals say Medicaid's replacement needs to be tailored to fit children's needs.

Conclusion

NACHRI has applauded the President's leadership in making health care reform a national priority and we have supported many principles reflected in his legislation: universal coverage, comprehensive benefits, employer-based coverage, assurance of choice among health plans, recognition of the roles of essential providers of care to low income patients and academic health centers treating rare conditions, separating the financing of graduate medical education from patient care reimbursement, sustaining Medicaid eligible children's access to medically necessary care, and more.

A number of other important proposals also attempt to address these basic principles, and in the months ahead, this subcommittee will help lead the Congress to forge a winning consensus to achieve what all Americans, and especially parents, hope for: reliable and affordable health care coverage that meets our needs and our children's needs. NACHRI believes it is important for that consensus to be shaped by an understanding that reform must be tailored to fit children's needs, and if it is based on competition, the competition must be managed so kids win, too.

Mr. Chairman, thank you for the opportunity to present NACHRI's views on health care reform.

Chairman STARK. Dr. Staggers.

STATEMENT OF BARBARA STAGGERS, M.D., DIRECTOR OF ADOLESCENT MEDICINE, CHILDREN'S HOSPITAL OAKLAND, ON BEHALF OF THE CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION; ACCOMPANIED BY SUSAN MADDOX, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

Dr. STAGGERS. Thank you, Mr. Chairman. It is my pleasure to be here. What I would like us to think about as we move toward considering fiscal manners regarding health care is that we don't overlook the extremely vulnerable population of children in this country. In addressing matters of health care reform, managed care, all the things we have been talking about today, issues of who consents to care for children, issues of adolescent confidentiality, access to care, et cetera, are often ignored or never addressed. And my concern is if this happens, those of us who work in children's hospitals and care for children like I do, literally end up picking up more bodies.

Therefore, there are some things that we thought about at the California Children's Hospital Association and my colleagues in adolescent medicine that we think are important when you consider or when you propose any health care reform legislation.

One in the area of adolescent health care is that any health care reform must understand that adolescents really still are children. They are not adults. They have highly specialized needs, and the health care reform must address adolescent needs in terms of their ability to make consent, their ability to access care, and confidentiality which they have a right to in terms of their own medical services, and we are extremely concerned about that.

As I represent the California Children's Hospital Association, there are three things we are concerned about. One is that any legislation ensure that specific language in the reform bills designate children's hospitals as essential providers, or another similar designation given to safety net or traditional providers, require all managed care plans to contract with children's hospitals and keep their pediatric networks in place, to keep pediatric primary care and specialty care appropriately available to children.

Children's hospitals are special. They are designed, implemented, and planned to meet the needs of children, youth and their families. They do this in a way that helps promote transition from infancy to young adulthood. It is important to understand and underscore the special services children's hospitals give when you are talking about health care reform.

Also, preservation of disproportionate share payments is important to supplement Medicaid programs if they continue to exist, or funding some sort of equivalent program to ensure coverage for vulnerable populations. Children's hospitals average 60 percent Medicaid in some cases and cannot make up that shortfall through cost shifting or other windfalls, since I have never seen a windfall yet in our hospital.

Even for those of us who are adolescent service providers, it is even more critical because in the State of California, even if your parents own General Motors and you want to come in for confiden-

tial services, you are eligible for Medi-Cal, which means that as an adolescent, for you to get health care access, you are going to be on a State supplemented program. So 90 percent of my patients are Medi-Cal, which does not make me real attractive to the hospital for obvious reasons on specific things.

Third, that title V programs that we know that work well in California for children with special needs, like diabetes, like sickle-cell disease, like cystic fibrosis, asthma, that they stay in place, because they are good demonstration projects for targeting children with special needs. These children require timely interventions in very high specialty referrals and service networks.

In California, California's service programs, CCS as it is known by us, is the oldest, most successful managed care program in the State. We consider it a model. We are looking at integration of the CCS program into the California's Medi-Cal managed care system, and pilot programs, like those that are happening in California, need to be looked at when you are making decisions about health care reform.

As a provider, I know the four things I talked about in terms of issues for adolescents, in terms of them accessing and appropriately utilizing any health care plan, issues of preservation of title V programs, ways to reimburse the hospital in terms of disproportionate share payments, and specific language making children's hospitals essential providers will be critical for maintaining the level of health care services we have for children, and that concludes my comments.

Chairman STARK. Thank you, Dr. Stagers.

[The prepared statement follows:]

**TESTIMONY OF BARBARA STAGGERS, M.D.
CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION**

Mr. Chairman and members of the Committee, my name is Dr. Barbara Staggers and I am the Director of Adolescent Medicine at Children's Hospital Oakland in California. On behalf of Children's Hospital Oakland and the families it serves, I thank you for the opportunity to testify before the Committee today.

Children's Hospital Oakland treats children up to early adulthood and integrates patient care, teaching and research. The medical center serves children from 46 of California's 58 counties, drawing patients from surrounding states and Pacific Rim countries and offers satellite subspecialty services in the cities of Fairfield, Pleasanton, Santa Rosa and Walnut Creek. With 205 beds and 32 subspecialties, Children's Hospital Oakland also has an impressive team of pediatricians and subspecialists --- 130 based in the hospital and 450 in the community.

Children's Hospital Oakland is very much attuned to the inner city problems existing in our neighboring communities where teen-age rape and pregnancy, child abuse and juvenile crimes are unfortunately common incidences that are on the rise. We not only provide specialty care services but also primary care to meet the needs of children in the inner city. We see approximately 25,000 patients a year in our primary care clinics --- these children are considered "mentally and socially fragile". Mental health services are extremely difficult to find for these children.

In the Adolescent Medicine department which I direct at Children's Oakland, we see almost 12,000 youths between 11 and 19 years old who belong to a new at-risk population of children in the United States - teenagers. To give these difficult-to-reach young people access to healthcare, we have developed a comprehensive community collaborative healthcare system which operates a Teen Clinic at the hospital, school-based clinics at Oakland high schools, peer counseling/adolescent advocacy programs, and a spectrum of treatment from preventive care to intensive hospitalization.

The leading causes of death among young people are motor vehicle injuries, suicide and homicide. Make no mistake about this: it's the same leading preventable causes of death whether the teenager comes from an inner city or a wealthy suburb. For me, all high-risk behavior such as teen pregnancy, escalating violence and substance abuse are all symptoms of a larger disease. A lot of youths are looking for love and support in all the wrong places. We need to look at every teen and say, "What's going on in your life? How can we help you grow?"

It takes extra time, special skills and expertise to work with adolescents, to find out that a patient who presents with asthma or a broken arm is also dealing with having been raped, experienced violence at home or attempted suicide last week.

This is not traditional medicine, or the medicine I was trained for. But it's the kind of healthcare that children's hospitals are uniquely qualified to provide because they specialize in the needs of children, youth and their families.

We also have a Center for the Vulnerable Child that provides an innovative approach to the relationship between poverty and children's health. The Center sees approximately 1,200 patients per year and provides comprehensive services to children reported to have been sexually abused, those in foster care, and to chemically dependent women and their drug-exposed infants. Our neighboring communities have seen a rise in the number of Asian refugees. Children's Hospital Oakland opened a Southeast Asian Clinic in March, 1980, and now serve approximately 2,600 patients per year. Many of these children have parasites, are anemic, have positive TB skin tests, poor growth associated with poor nutrition and some have malaria, pneumonia or war scars and burns.

Children's Hospital Oakland is by no means the only facility serving children in need. The seven Children's Hospitals in California all serve their communities and children in very much the same way that we do. As a member of the National Association of Children's Hospitals and Related Institutions (NACHRI), Children's Hospital Oakland supports NACHRI's recommendations on health care reform and children. I am here today to speak to California-specific issues that concern the seven Children's Hospitals in California, including Children's Hospital Oakland. These concerns have been expressed through the work and representation of the California Children's Hospital Association (CCHA).

The California Children's Hospital Association

CCHA, under the leadership of President and Chief Executive Officer Susan Maddox, represents seven not-for-profit children's hospitals located in Oakland, Palo Alto, Fresno, Los Angeles, Long Beach, Orange, and San Diego. Together these institutions, which represent less than 2% of the state's hospitals, provide approximately 30% of all hospital care needed by Medicaid-eligible children in California and an even higher proportion of the care for children with special health care needs. CCHA's mission is to strive to advance the health and well-being of children by taking a leadership role in advocacy, public policy, education, and research in support of a California children's health care delivery system. CCHA advocates a balanced approach to health care reform which improves child health status by increasing access to prevention and primary care services for all children while preserving access to high quality specialized care when still needed. In the maintenance of this balance, CCHA supports the protection of the well-being of children in health care reform, ensuring Children's Hospitals as "essential providers," maintaining existing sources of funding during the transition to managed care, and encouraging the development of integrated pediatric networks.

The Children's Hospitals fully understand the fiscal pressures facing the state and federal government. Given that financial resources are scarce, the Children's Hospitals strongly advocate that, at a minimum, all children in the U.S. should come first and be taken care of. Children are our country's most precious resource and are our future.

The seven Children's Hospitals have concerns regarding health care reform and the potential effect on California's children. These concerns stem from key California-specific statistics and the unique role of Children's Hospitals from other adult facilities.

1. Children's Hospitals have the highest concentration of Medi-Cal (California's Medicaid program) patients of any hospital type. Over 60% of their patients are covered under Medi-Cal, versus about 15% at contracting hospitals statewide.
2. A disproportionately high number of children served by Children's Hospitals have special health problems and needs --- approximately 70% of the Medi-Cal days in Children's Hospitals are for Medi-Cal children with medical conditions so serious that they qualify for the California Children Services (CCS) Program, the state's version of its Children With Special Health Care Needs (CSHCN) Program under Medicaid's Title V program. These are truly society's sickest children. Over 67% of the patients seen at Children's Hospital Oakland are Medi-Cal children qualified for CCS.
3. Children's Hospitals treat sicker patients than most general hospitals. Almost 33% of Children's Hospitals' beds are designated for intensive care, compared to an average of 11% in general hospitals. More than 80% of Children's Hospitals' beds are occupied on an average day, while the statewide average is just over 50%.

4. California has the highest number of illegal immigrants residing in the state. There are over 2 million illegal immigrants, over 50% of the nation's total, living in California. It is estimated that 392,000 illegal immigrant children are between the ages 5 to 17. These children did not make a conscious decision to break the law to cross the state border.
5. In 1992, there were at least 96,000 Medi-Cal children (40% of all Medi-Cal births) born to illegal immigrants.
6. The exorbitant number of illegal immigrants has placed a high burden on the state. It is estimated that federally mandated services, including health, cost California taxpayers \$2.5 billion per year.
7. Children's Hospitals have long recognized their responsibility to the children of California and have steadfastly upheld their long-standing mission to care for all children, regardless of ability to pay and citizenship status.
8. In California, approximately 70% of the patients in an average Children's Hospital are either charity patients or are covered by government programs (such as Medi-Cal or CCS Program) where the basic payments fall far short of the cost of care.
9. During the 1991-92 fiscal year, Children's Hospitals lost \$22 million dollars on outpatient services provided to Medi-Cal children. This loss figure is the difference between actual costs (not charges) and reimbursement received. Preliminary data from six Children's Hospitals show that our member hospitals have experienced, on average, a 5% increase in Medi-Cal outpatient visits with an estimated shortfall of \$33 million dollars in 1992. This represents a 50% increase in the shortfall from the 1990-91 fiscal year.
10. The state's on-going recession and high unemployment rates (higher than the national average), coupled with the fires and recent earthquake in Los Angeles, places increasing burden to California residents and state budget.

In the context of health care reform, the Children's Hospitals urge you to keep in mind the following points:

Ensure that Children's Hospitals receive status as "essential providers" or another similar designation given to safety net providers --- Children's Hospitals are safety net providers by virtue of their high concentration of Medi-Cal patients (on average over 60% of each of their total patient load) and represent a wealth of experience in providing the broadest range of services to all children, from primary to long-term care. As a result, Children's Hospitals should receive "essential provider" status to ensure that all managed care plans and the children within their plans have access to pediatric experts and services.

Preserve disproportionate share payments (DSH) to supplement the Medicaid program shortfall or fund an equivalent program to ensure coverage for vulnerable populations --- Vulnerable populations --- children born to illegal immigrants, children on Medicaid, and those with special health care needs --- are at greater risk of receiving inadequate care. This risk will dramatically increase if certain protections are not in place as health care reform unfolds. Children's Hospitals recognize their responsibility to all children and have steadfastly upheld their mission to refuse no child that enters their hospital doors. During the health care reform debate and early stages of implementing changes to the nation's health care delivery system, Children's Hospitals advocate for the preservation of DSH payments to supplement the Medicaid program to ensure that every child is able to receive needed health care services and to ease the shortfall experienced by providers, such as Children's Hospitals, dedicated to serving vulnerable populations. Charitable donations and cost shifting to the few insured patients is inadequate. Medicaid disproportionate share hospital payments will

continue to be critical to Children's Hospitals as long as the basic payments fail to cover the costs of the care delivered. Universal coverage alone will not protect the disproportionate share safety net hospitals when only sixty cents on the dollar of cost is reimbursed. It is also imperative that prepaid health plan (PHP) Medicaid days be counted in the calculations for DSH allowances.

Preserve Title V Programs, particularly funding for programs for children with special health care needs --- Approximately 70% of the Children's Hospitals Medicaid recipients are children with special health care needs served by the California Children Services (CCS) Program, the state's version of its Children With Special Health Care Needs (CSHCN) Program under Medicaid's Title V program. The CCS Program is designed to assist families meet the financial burden of caring for children under 21 with severe physically handicapping conditions. The program helps to ensure that the state's children receive only the most appropriate and highest quality pediatric care possible. CCS is one of a limited number of programs that sets medical standards for its CCS-approved providers (physicians, nurses, physical/occupational therapists, and hospital facilities such as special care centers) to treat children with CCS-eligible conditions. These standards ensure that chronically ill children are cared for by professionals who have significant experience in pediatric specialty care. The CCS Program serves as a model for other health systems trying to control rising health care costs and ensures that care is provided using the most cost-effective means by emphasizing early intervention and access to primary care. CCS provides a unique combination of case coordination and case management rarely found in state programs. CCS case management goes beyond the inpatient utilization review common with other programs by assuring that appropriate outpatient and follow-up care are given by qualified providers.

Encourage innovative state programs and/or demonstration projects targeting children with special health care needs --- California has taken a unique approach towards health reform within the state. The California State Department of Health Services Strategic Plan, "Protecting Vulnerable Populations," details the Department's commitment to expand managed care for Medi-Cal beneficiaries as the most cost-effective way to improve access to quality preventive and primary care services. The Strategic Plan recognizes that traditional managed care approaches may inadequately serve the needs of children with chronic or acute conditions, such as those with CCS-eligible conditions. These children require timely intervention and specialty referral. The Strategic Plan excludes CCS services from the expansion of Medi-Cal managed care. The Children's Hospitals, in collaboration with other providers in the community, are currently working with the state in developing and implementing pilot projects to test a variety of managed care models tailored to the needs of this most vulnerable population. The Children's Hospitals strongly advocate that a similar approach be taken at the national level, perhaps in the form of federal demonstration projects, to protect these children as the country moves towards health care reform.

Conclusion

The seven Children's Hospitals in California commend the President in making health care reform a priority on the national agenda. We strongly urge the President and members of Congress to keep in mind the needs of all children in the U.S. They are the next generation and the future of our country rests on them. Minimally, the early stages of health care reform should ensure that our children are protected first before anyone else. Mr. Chairman and members of the Committee, I thank you for the opportunity to present the views of California's Children's Hospitals. We stand ready, as always, to assist in any way that we can.

Chairman STARK. Mr. Goldsmith.

STATEMENT OF MARTIN GOLDSMITH, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALBERT EINSTEIN MEDICAL CENTER, PHILADELPHIA, PA., ON BEHALF OF THE NATIONAL ASSOCIATION OF URBAN CRITICAL ACCESS HOSPITALS

Mr. GOLDSMITH. Thank you, Mr. Chairman. My name is Martin Goldsmith. I am president of Albert Einstein Medical Center in Philadelphia and I am here today in my capacity as president of the National Association of Urban Critical Access Hospitals.

Our group consists of urban hospitals that depend on government to an unusual degree to pay for the care we provide. By urban critical access, we mean that we are private nonprofit, located in cities, large and busy. We are the largest providers of care to the elderly, the poor and the underinsured, fulfilling much the same role as public hospitals in the many cities in which there are no public hospitals, and in other communities working alongside those public hospitals.

Because much of this care is paid for by Medicare and Medicaid, the outcome of the health care debate will have a major impact on us. More important, that outcome will have a profound and lasting impact on our communities. For the unusually large number of elderly and poor people who rely on us for care, we are essential and irreplaceable.

We are in favor of health care reform. There is much in H.R. 3600 that we support. We enthusiastically support the extension of medical benefits to all Americans, portability of benefits, the ending of limits on those with preexisting medical conditions, and the integration of Medicaid population with the rest of the public.

Despite these improvements, H.R. 3600 also includes several provisions that would jeopardize our ability to continue serving our large urban poor and elderly communities. We think it is essential that you preserve the worthy provisions of H.R. 3600, correct those that cause problems, and adopt reform legislation this year. There really is a health care crisis and we can't afford to wait another year to do something about it.

Now I would like to outline a few of those problems I mentioned. First, the Medicare cuts proposed in H.R. 3600 would be devastating and it would hit our member hospitals much harder than the average hospital. According to a study based on the bill and on HCFAs testimony before this committee in December, the 10 hospitals that meet the criteria for urban critical access in my own city, Philadelphia, would each lose on average \$116 million during the first 5 years of this plan, jeopardizing our long-term ability to continue providing our poor and elderly patients with the quality and scope of service they deserve and that everyone else would be receiving.

Hospitals in the city of Philadelphia as a whole would lose \$1.5 billion in Medicare revenue during that same period and thousands of jobs would be unquestionably lost. We can provide you with a summary of losses in other cities and explain how we arrived at those figures.

Second, under this bill, we would continue to be responsible for a good deal of uncompensated care, especially for the many undocu-

mented aliens in our inner cities. In addition, many people will be unable to afford their copayments and deductibles, and some may refuse to purchase insurance. The financial impact of providing this additional uncompensated care would be much greater on us than the average hospital.

Third, while this committee's jurisdiction does not extend to Medicaid, I would like to mention that H.R. 3600 would eliminate Medicaid disproportionate share payments before those payments would be replaced by universal coverage. This would be yet another devastating blow to us.

The most important thing, of course, is what this means to our inner-city communities. Our hospitals have long been the primary care providers—the primary providers of care for the urban, elderly and poor, but portions of H.R. 3600 would jeopardize our existence and discourage others from fulfilling that void.

We believe that H.R. 3600 is basically a sound bill and can be amended to rectify these problems and insure the future of urban critical access hospitals.

First, these hospitals should be designated as essential community providers. By any reasonable measure, we are essential to our communities and need to be preserved. Second, eliminate the inequitable impact of the proposed Medicare cuts because of the destructive effect they would have. Third, reimburse these hospitals appropriately and directly for the continuing and substantial uncompensated care they provide. Fourth, restore our Medicaid disproportionate share payments until they are fully replaced by universal insurance or another mechanism, and insure providers they will be paid adequately to care for Medicaid recipients. Risk adjusting payments to plans does not provide any assurance of adequate payment to hospitals. And fifth, through statute, create a rapid response system to monitor the effects of the changes stimulated by reform and create a system which will correct any unanticipated, undesirable effects on our community quickly.

This would be the desired outcome. We continue serving our communities, the poor and elderly receive the care they deserve, and you implement an effective, efficient groundbreaking program without sacrificing access to care for the elderly and poor who need it the most. I appreciate this opportunity to address the committee this afternoon and will be delighted to answer questions.

Chairman STARK. Thank you.

[The prepared statement follows:]

**Testimony of
Martin Goldsmith
President
National Association of Urban Critical Access Hospitals
before the
Subcommittee on Health
of the
House Ways and Means Committee
February 7, 1994**

Greeting

Good afternoon. Mr. Chairman and members of the committee, my name is Martin Goldsmith, and I am president and chief executive officer of the Albert Einstein Medical Center in Philadelphia. I am here today to address the Health Subcommittee of the House Ways and Means Committee on behalf of the National Association of Urban Critical Access Hospitals, to express our support for the vast majority of H.R. 3600, including its goals and its basic approach, but also to describe to you how and why we fear that certain aspects of this bill will jeopardize access to health care for the poor and elderly in America's inner cities. I also will outline how this problem can be addressed and corrected.

About the Association

I would like to begin by telling you briefly about our organization. The National Association of Urban Critical Access Hospitals was formed last year to represent urban hospitals that depend to an unusual degree on government reimbursement for the care we provide. This is the case because so many of the patients we serve are elderly and poor and receive Medicare and Medicaid benefits.

We call ourselves "urban critical access hospitals" because we believe we are essential to access to care for the residents of many urban communities. We define "urban critical access" as consisting of the following qualities: our hospitals all are private, non-profit, and located in cities as defined by the census bureau; we are reimbursed for at least fifty-five percent of our patient days by the combination of Medicare and Medicaid, and at least ten percent by Medicaid alone; and our total hospital days must be at or above the sixtieth percentile of hospitals in comparably sized Metropolitan Statistical Areas (MSAs). In our view, the combination of these characteristics makes us essential to access to care in our communities and virtually irreplaceable to those communities. In many of those communities, in fact, urban critical access hospitals fill the same role as that of public hospitals: we care for the poor, the elderly, and the uninsured – that is, for people who frequently have nowhere else to go for medical care.

Not many hospitals meet our criteria for "urban critical access hospitals." According to our research, fewer than five percent of this country's hospitals, only 276 of 6600, qualify for this designation.

Our View of Health Care Reform

As providers on the front line of the health care delivery system, we are enthusiastic about the prospect of health care reform. Many of the reform proposals we have seen have a great deal to offer, and most would be a vast improvement over the system we have today.

We are here today to speak about H.R. 3600, which was introduced by Majority Leader Gephardt, and again, we find a great deal to applaud in this bill. We are especially

delighted by the steps it would take to bring health care coverage to unprecedented numbers of Americans. We also support the portability of benefits it would provide.

Despite these significant improvements, we are troubled by several aspects of this plan. Before we address those aspects, though, we want to reiterate our view that on the whole, this proposal has great promise. We do not want that message to be lost amid everything else we say today.

Summary of Three Major Problems in H.R. 3600

With that said, I would like to turn now to the three major problems we have identified.

First, we are greatly troubled by the size of the proposed Medicare cuts and the uneven, inequitable manner in which they would affect American hospitals.

Second, we believe that the plan may not address the uncompensated care issue as completely as some observers feel and that this may cause continuing problems for some providers, especially urban critical access hospitals, and for the largely low-income and elderly communities that they serve.

And finally, we are concerned about several of the potential side-effects of how the plan would serve Medicaid recipients.

Problem #1:

The Use of Medicare Funds to Finance Health Care Reform

■ The Unequal, Inequitable Impact of Proposed Medicare Cuts

Our first concern is the proposal to use reductions in the growth of future Medicare spending to finance health care reform. These sizable and unprecedented cuts specifically and directly hit urban critical access hospitals, and they would be devastating to us. The proposed cuts in graduate medical education, indirect medical education, Medicare disproportionate share, capital payments, and the rate of growth of future DRG rates especially affect hospitals such as ours, and they clearly would hit us hardest. If adopted, they would fall most heavily on urban critical access hospitals, the same hospitals that provide most of the care to the elderly and the poor in our nation's cities. They would affect all hospitals, but they would hurt ours the most.

These conclusions, moreover, are based not on assumption or conjecture but on hard data. We suspected instinctively that these cuts would hurt us, but we knew we needed some numbers to substantiate our fears. With this in mind, we made financial projections based on H.R. 3600. Using the analysis of the Prospective Payment Assessment Commission, testimony before this committee by Bruce Vladeck, administrator of the Health Care Financing Administration, other publicly available information about the plan, and 1990 Medicare hospital cost reports, we developed computer models to simulate the effect of the Medicare spending cuts on all hospitals, not just on urban critical access hospitals.

The result of this modeling was startling – and bad news for us, exceeding some of our worst fears. We found that together, all hospitals would lose an average of 7.16 percent of their Medicare revenue a year for the first five years under H.R. 3600. As we feared, this burden would not be evenly or fairly shared. Hospitals that are not urban critical access hospitals would lose less than that average, only 6.93 percent, but urban critical access hospitals would lose far more than that average – 11.5 percent of their Medicare revenue a year during the first five years. Our loss would be almost twice that suffered by other hospitals.

This country's urban areas and the hospitals that serve them would suffer extraordinary financial losses. New York City's hospitals, and the city's economy, would lose an astounding \$4.4 billion, just in Medicare inpatient revenue, during the first five years, and along with that money an as-yet uncalculated number of jobs. Other cities would suffer, too. Philadelphia would lose \$1.5 billion, Los Angeles \$715 million, Chicago \$1.3 billion, Boston \$954 million, Houston \$575 million, and Seattle \$316 million.

Not surprisingly, these lopsided geographic losses of Medicare revenue translate into a similarly skewed effect on individual hospital revenue. These spending cuts would cost the average hospital that is not an urban critical access hospital 1.38 percent of its overall revenue, but urban critical access hospitals would lose 2.37 percent. That may not sound like a big

difference, but it is when you consider that our loss would be seventy-two percent greater, and it is when you realize that hospital operating margins typically are only in the lower single digits.

■ The Financial Impact on Individual Hospitals

Let me give these numbers some immediacy with an example that hits very close to home for me: how they would affect my own hospital, Albert Einstein Medical Center. In the first year alone under H.R. 3600, we would lose \$15.8 million. In the second year, we would lose another \$21.3 million. During the first five years under the plan, Einstein would lose \$140.5 million.

I do not think I have to tell you that this is an extraordinary amount of revenue for a hospital to lose. Even so, I would like to take a moment to outline what that loss would mean to a hospital such as Einstein and to all of the other urban critical access hospitals that would find themselves in similar positions.

Those losses would come right out of our operating margins, which would decline and in some cases disappear. Like many other hospitals, the losses we would suffer will exceed any margins we have ever made. Without doing anything wrong, without failing to implement cost-saving measures, without losing even a single patient, we immediately would fall a huge step behind other hospitals in our service areas.

Operating margins are important to hospitals. They provide the cash flow we need to pay bills, service debt, and maintain our current facilities – that is, to pay for the things we must do to ensure that those who rely on us for access to the health care delivery system enjoy the same high quality of care as everyone else. The money we need to provide these services comes from our operating margins, but suddenly, those margins will be gone.

The losses we would suffer would be both absolute and relative. As I noted a moment ago, we would lose much more on a dollar-for-dollar basis than other hospitals. For every \$100 in Medicare revenue that hospitals that are not urban critical access hospitals receive, they would lose an average of \$6.93; we would lose \$11.50. This is a large and significant difference.

But even that does not tell the entire story, because Medicare is a bigger and more important part of our payer mix than it is at the average hospital. A hospital three or four miles from us may receive twenty or thirty percent of its revenue from Medicare, but urban critical access hospitals receive forty or fifty percent. This means that the difference between \$11.50 and \$6.93 is multiplied many more times for us than for other hospitals.

■ The Impact on Urban Critical Access Hospitals

This difference has significant implications for the ability of urban critical access hospitals to compete for patients. Keep in mind that one of the goals of health care reform is to eliminate cost-shifting. In the past, we would have sought to make up this difference by passing it along to other payers. In fact, government, by underpaying us for Medicare and Medicaid, has effectively encouraged us to do so. Now, though, government suddenly wants us to reverse fields. In a managed competition environment, anyone who tries to pass along costs to other payers will lose that competition and will not have other payers.

Consider, moreover, that one of the primary ways that we hope to control rising health care costs is through greater use of managed care. In the future, hospitals will compete to be parts of managed care networks, and that competition will really be decided based on just one consideration: price. The hospitals that offer the best prices to managed care plans will become part of their provider networks; the others will be left out in the cold.

But urban critical access hospitals are going to suffer significantly larger Medicare losses that we will need to make up, so we will have to price our services accordingly. We may have to charge a little bit more than hospitals that do not suffer those losses, or that lose less. As a result, we may lose in our bids to become part of those networks. That is not managing competition: it is limiting competition.

There is a certain irony here that is hard to miss. Much of health care reform is about using market forces to control escalating health care costs, but the very plan that purports to put those market forces to work would put some of the competitors at a major disadvantage before the competition even begins.

So what, you may ask. If managed competition means that a few hospitals fail and close, is this really a problem? In theory it may not be, but in practice, it is.

By virtue of how we define ourselves, urban critical access hospitals play an unusually large role in the care of the elderly and the poor in their communities. We are their essential link to the health care community, in some cases their only link, because historically, just a few of us provide most of the care to the elderly and the poor. Whether it is because our services are more oriented to their needs or because our location is more accessible or because we have consistently made a point of reaching out to them, we have become the primary providers for many people.

If we are not there to provide this care, it is likely that no one else will be, either, that no one else will be willing to step forward to fill the void that we would leave behind. The proposed reform, in fact, would punish them for doing so. Having a health security card will be meaningless if there is no one to provide care when people need it, so we think it does matter whether our hospitals survive. We are irreplaceable resources in our communities.

While the proposed Medicare spending cuts could threaten hospitals that care for the poor, providing unprecedented coverage and access to care for the uninsured at the same time that we propose significantly underpaying for Medicare services could jeopardize access to care for the elderly. If health care providers suddenly are paid much better to care for the poor than for the elderly, Medicare recipients would become a much less attractive pool of patients for providers.

For these reasons, H.R. 3600's plan to finance health care reform with cuts in future Medicare spending could have the unintended effect of reducing access to care in our communities. These cuts in graduate medical education, indirect medical education, Medicare disproportionate share, capital payments, and the rate of growth of future DRG rates hit urban critical access hospitals especially and disproportionately hard. They would jeopardize our ability to compete in a managed competition environment and they would jeopardize our ability to survive.

■ Impact on the Urban Poor and Elderly

Now, let us take a moment to look at what really matters: how all of these numbers and projections and prognostications would affect the people and the communities we serve and how we serve them.

These changes most likely would have their greatest impact on the elderly and the poor. The significant reductions in hospital revenue that I described will jeopardize the financial wherewithal of many hospitals that care for especially large numbers of Medicare patients. In some cases, those hospitals may have to reduce or eliminate individual patient services that lose large amounts of money because of these spending reductions. Special outreach programs, for example, or services designed specifically for the elderly, might have to be ended. In some communities, that may even be a best-case scenario, because we believe that the proposed Medicare spending reductions may very well force some hospitals to close entirely, leaving large numbers of elderly patients to fend for themselves, to find new sources of care in an environment in which new public policies have made Medicare recipients the least desirable patients a hospital can attract.

In cities, moreover, elderly people tend to be low-income as well, and they tend to live among other low-income people. This, in turn, means that if hospitals serving large numbers of Medicare patients reduce services or close, the large numbers of poor patients that those same hospitals serve also would find themselves suffering greatly reduced access to care. Thus, for the elderly and the poor, health care reform, as currently proposed in H.R. 3600, could be an unmitigated disaster.

H.R. 3600 provides for the designation of selected hospitals as "essential community providers" and for those hospitals to receive special consideration when necessary. We believe that urban critical access hospitals truly are essential community providers. We serve unusually large numbers of people who are totally dependent on government for their medical care; we do so in communities where there are no other providers, not enough other providers, or where other providers specifically seek to avoid serving these patients; and our disappearance would cause irreparable harm, leaving many of the urban low-income, elderly, and poor without adequate access to medical care. By any reasonable measure, urban critical access hospitals are essential community providers and deserving of such designation.

We do not believe for a moment that it is the Administration's intention to jeopardize the future of these hospitals, nor do we believe it is this committee's desire. We share your commitment to controlling health care costs, but not at the expense of reducing access to care.

If we do, we truly will control costs, because for some people, there will be no care, and from the narrow perspective of those who keep the books on these things, no care will cost us nothing, although we would pay a fearsome price of an entirely different kind.

■ Our Recommendation

To address this problem, we propose that urban critical access hospitals be among those designated as "essential community providers" under H.R. 3600 and that hospitals with such special missions be accorded appropriately special consideration. The Medicare reimbursement provisions of H.R. 3600 then would be re-evaluated and readjusted with the unique situations of these hospitals in mind. Further, because it may be difficult to predict whether the adjustments ultimately made will adequately resolve the problems they were implemented to address, additional provisions should be made to monitor their effectiveness through a specifically designated mechanism such as an annual review or report to Congress; those same provisions should authorize the Administration to make any adjustments found necessary based on these reviews. Such steps are essential if we are to assure that health care reform reaches the inner-city communities where such reform is needed most.

Problem #2: Continued Uncompensated Care

The second issue I would like to address today is what we fear will be a continued problem with uncompensated care.

Beyond any reasonable doubt, H.R. 3600 would, if enacted, greatly reduce uncompensated care. Contrary to what has been suggested, however, uncompensated care would not disappear completely, and its continuation would most affect urban critical access hospitals.

■ Four Areas Where Uncompensated Care Will Continue

Uncompensated care would endure through four primary means.

First, most health care plans would require their members to make co-payments and reach deductibles, yet some people, especially the poor and the unemployed who are not eligible for Medicaid or other government subsidies, would not be able to afford these payments. Hospitals would be expected to absorb those costs.

Second, some people would be unable to purchase health insurance or would choose not to do so, but they would continue to seek care. When they do, hospitals will not turn them away; again, they would provide the care and absorb the cost of doing so.

Third, some Americans are "lost" today. They are not employed, so they would not be covered through their place of business; they are not old, so they would not be covered by Medicare; and while they are poor, they do not receive Medicaid or other government benefits. Most are homeless, and when they come to a hospital, they would be lost no longer. At that point, they would join the ranks of the insured, but the cost of their first hospital visit, whether for a scrape suffered in a fall or a near-fatal illness, may have to be absorbed by the hospital. Insurers may not be expected to provide retroactive coverage for new enrollees.

Fourth, this country has a significant number of undocumented aliens who would not be covered by health reform. While H.R. 3600 proposes some funding for the care of undocumented aliens, that sum is nowhere near the cost of the services that those individuals would consume. As a result, undocumented aliens would continue to receive hospital care, but hospitals would not be paid for their services.

All of the groups that avoid the umbrella of protection raised by health care reform – the poor, the lost, and the undocumented – can be found in especially large numbers in America's cities. In those cities, the same basic core of hospitals – critical access hospitals – would be the providers to which they turn. Consequently, urban critical access hospitals would bear a disproportionate share of the cost of caring for them.

Again, you may question whether this really is a problem, and again, we must express our view that it is. One of the ways that H.R. 3600 seeks to contain rising health care costs is by fostering price competition among health care providers. By failing to accommodate the remaining uncompensated care, the plan would add to the operating costs at a relatively small number of hospitals, placing those few hospitals – mostly, urban critical access hospitals – at a decided financial disadvantage before the competition even begins. In so doing, it threatens the

financial survival of the very hospitals that are and will continue to be the providers of choice among the poor and the elderly in most American cities.

We also must not lose sight of the human factor. Under these circumstances, some people who cannot afford insurance or co-payments or deductibles will try to put off seeking medical attention for as long as they can. Some who are sick will get sicker; some who have contagious diseases will pass them along to others; some who support families will no longer be able to do so; some who are pregnant will give birth to unhealthy babies; and some who have treatable diseases will die. This should not be the legacy of health care reform. We can do better, and we must.

■ Our Recommendation

The National Association of Urban Critical Access Hospitals supports H.R. 3600's goal of ensuring universal access to health care yet notes that the bill does not guarantee actual health care for all. The Association feels that providers must be adequately reimbursed for the uncompensated care they provide, regardless of to whom they provide it. Anything less leaves just a few hospitals, America's urban critical access hospitals, to shoulder a financial burden that should be the entire country's to bear.

Problem #3: How the Reform Proposal Would Affect Medicaid

Finally, I would like to turn to the manner in which H.R. 3600 deals with Medicaid. Because Medicaid does not fall under the jurisdiction of this committee, I will touch on this subject just briefly.

■ The Premature Phasing Out of Medicaid Disproportionate Share

Our first concern is the bill's call for phasing out Medicaid disproportionate share payments by 1997. While we understand the rationale for ending these payments, we are mystified by the timetable for their termination.

Even the most optimistic estimates do not envision the full implementation of universal health insurance by 1997. Consequently, Medicaid disproportionate share payments could be eliminated well before the changes that are supposed to make their elimination possible are even implemented. This may leave a gap of a period of years during which disproportionate share hospitals would continue caring for unusually large numbers of poor patients without the supplemental support of their Medicaid disproportionate share payments. This could place an enormous financial burden on these hospitals — especially on urban critical access hospitals, with their large numbers of Medicaid patients.

■ Our Recommendation

The National Association of Urban Critical Access Hospitals believes that Medicaid disproportionate share payments should not be phased out before the rest of the reform plan, including universal health coverage, is phased in. To do otherwise could expose disproportionate share hospitals, and especially urban critical access hospitals, to potentially devastating financial losses. This, in turn, could jeopardize access to care in the communities that these hospitals serve.

■ Providing Private Insurance for Medicaid Recipients

We also are concerned about how H.R. 3600 may change the way Medicaid recipients are served. Under the plan, Medicaid recipients would join the premium-paying public in choosing from a selection of insurance plans. Their choice, though, would be limited to plans that are at or below the weighted average of cost for plans available through their health alliances.

We believe this policy may have the unintended effect of creating Medicaid-only health plans. Because Medicaid recipients would be required to choose from among the lowest cost plans, they may, from the very beginning, constitute unusually large proportions of the members of those plans. Eventually, we believe those plans may come to be viewed as plans primarily for Medicaid recipients and that people who have a choice may specifically choose not to join these "Medicaid plans."

The result could be that some plans may consist primarily or even entirely of Medicaid recipients. We believe this could have a very undesirable effect. Historically, the poor are sicker than others and correspondingly more costly to treat. As a result, we may be directing the most expensive patients into the lowest-cost plans. Because they have the lowest premiums, those plans may have to pay the lowest rates to their contracting providers. Thus, hospitals that care for Medicaid recipients could be responsible for the extra costs incurred through the higher utilization that comes with treating a poorer, sicker population, as well as for the kinds of supplemental services that many Medicaid recipients need but that are not reimbursed by Medicaid or other payers – services such as outreach efforts, home visits, and providing money for carfare or day care to enable patients to keep appointments with their doctors.

And who will those providers be? In many cases, they will be us: America's urban critical access hospitals. We are the providers of choice for unusually large numbers of Medicaid recipients today, and we are likely to remain the providers of choice for them tomorrow as well.

■ Our Recommendation

In the past, Congress has made it clear that it does not approve of Medicaid-only managed care plans. We have regulations against their use, and obtaining a waiver from those regulations is extremely difficult. While H.R. 3600 does not explicitly call for the creation of Medicaid-only plans, we believe that it ultimately may have that effect. We believe that any new method of providing health care coverage to Medicaid recipients should ensure that Medicaid-only health plans do not develop. Only through such a policy can the prospect of such plans and the continued inadequate reimbursement for Medicaid services be prevented. In addition, a means should be devised to assure adequate reimbursement to hospitals for the full cost of treating Medicaid recipients.

Summary of Recommendations

- Classify urban critical access hospitals as "essential community providers," a designation created in the bill.
- Alleviate the devastating impact of the proposed Medicare cuts by reducing those cuts. If that is not possible, refocus the proposed cuts in graduate medical education, indirect medical education, Medicare disproportionate share, capital payments, and the update factor so they do not have as devastating and disproportionate an impact on urban critical access hospitals.
- Develop a mechanism to reimburse urban critical access hospitals for the disproportionately large amount of uncompensated care they would continue to provide under H.R. 3600. This mechanism only needs to bring their uncompensated care obligations in line with those of other hospitals; it does not have to eliminate those obligations entirely.
- Refrain from phasing out Medicaid disproportionate share payments to these hospitals until everyone, including all Medicaid recipients and the uninsured, has complete access to health insurance. Currently, there would be a gap between the end of disproportionate share payments and the beginning of universal insurance coverage, leaving urban critical access hospitals responsible for millions extra in uncompensated care.
- Create a means of assuring that the requirement that Medicaid recipients choose from among health plans at or below the weighted average of cost among those offered by their health alliances does not result in the de facto creation of "Medicaid-only" health plans.
- Devise a method of adjusting risk for providers that serve Medicaid recipients. Historically, Medicaid recipients are more expensive to treat than the general population, so a mechanism is needed to protect insurers that pay for their care and providers that deliver that care.
- Create a statutory mechanism that directs the Administration to conduct periodic assessments of the impact of the changes outlined above on urban hospitals and the delivery of urban health care and to report those results to Congress. This mechanism also should authorize the Administration to make any adjustments necessary based on the results of these reviews. The purpose of such review is to

ensure that these changes are having the desired result, that the finances of urban critical access hospitals are not jeopardized, that the urban elderly and poor continue to have appropriate access to medical care, and that those hospitals are neither over-compensated nor under-compensated for their special role in serving the urban elderly and poor.

Conclusion

As I noted a few minutes ago, our organization views many aspects of H.R. 3600 with great enthusiasm. By appearing before this committee today, we hope only to call attention to a few of the bill's shortcomings, not to suggest that it be discarded entirely. We also urge you to act to pass health care reform this year; this issue is too important to wait another year.

As it is written today, H.R. 3600 could seriously jeopardize access to care in many American cities. It would penalize hospitals that care for large numbers of elderly and poor patients by detracting from their ability to compete for the opportunity to care for patients who are neither old nor poor, and this, in turn, could jeopardize access to care for the urban elderly and poor. It would leave some hospitals, mostly urban critical access hospitals, with an enduring uncompensated care problem while declaring this problem to be cured, and this could lead to new health problems among those who lack the means to pay their share of their health care expenses. And it would threaten to create a two-tiered health care system in which Medicaid recipients are alone in the second tier.

All of these problems are very real, and they concern us greatly, but we think that with proper attention, all of them can be rectified. By designating urban critical access hospitals as "essential community providers" under existing provisions of H.R. 3600, special efforts can be launched to refocus the cost-savings provisions of the proposed Medicare spending reductions so that they do not have a devastating impact on the very providers most involved in caring for the urban elderly and poor. In so doing, we can ensure that health care reform reaches the inner-city communities of America, where it is needed most.

We look forward to an opportunity to work with this committee, others in Congress, and the Administration to address these problems and move forward with reforms that truly benefit all Americans.

Chairman STARK. Mr. McNamara.

**STATEMENT OF HON. EDWARD H. MCNAMARA, COUNTY
EXECUTIVE, WAYNE COUNTY, MICH.**

Mr. McNAMARA. Mr. Chairman, members of the subcommittee, thank you for allowing me the opportunity to testify before you today. In Wayne County, Mich., we have for the past 7 years been tackling many of the problems of urban health care delivery that have now moved to the front of national debate. I am hopeful that some of our experiences may help your discussions.

With more than 2 million residents, including the city of Detroit, Wayne County is Michigan's largest county and America's 8th largest county. We have every problem of size, poverty and economic development that you can imagine, but we have also been successful in addressing many of these challenges in a productive and cost-effective manner.

We are here today because President Clinton's health care reform legislation calls for a radical overhaul of the Nation's health care system. We have already done that. While media attention was focused on other programs in New York and Hawaii, we think we have had some useful experiences in health care reform in Wayne County. We believe it would be helpful for us to tell you what we have learned along the way.

As Congress moves forward with consideration of health care reform, our experience in managed health care can serve as a national demonstration of delivering health care to the medically uninsured and underserved. If our experience can make your way easier, we are at your service to provide information. In other words, we have already groped around in the dark on this matter, stubbed our toes, banged our heads and now that we found the light switch, we hope we can help you avoid some stumbles in the path to health care reform.

Wayne County supports managed care as an effective way of providing health care to poor urban residents and controlling government costs. When I took office in 1987, Wayne County faced a deficit of \$135 million, due largely to uncontrolled indigent health care costs. Until that point, our poorest residents had no access to preventive health care. A woman with high blood pressure couldn't get medication to control it. She had no guaranteed access to treatment until she had a stroke and was taken to an emergency room. A man with diabetes had no doctor to write regular prescriptions for insulin. He needed to go into insulin shock and head for the emergency room. As you well know, emergency room care is as expensive as it gets. Untreated illnesses were killing our residents and the cost of the treatment was killing us.

Wayne County has no deficit today, thanks in large part to CountyCare, the managed care program for indigents we instituted in 1988. CountyCare was one of the first programs in the Nation to provide a comprehensive range of inpatient, outpatient, and home care service to the indigent population. Nearly 50,000 enrollees are members of our managed health care system which provides an HMO type approach to delivering health care services.

Under CountyCare, we bid our service contracts to private sector health care providers who treat enrollees for a flat rate of \$80 per

month per person. This puts the incentive on providers to offer convenient, preventive care. It is far more profitable to pay for blood pressure pills than heart surgery. As a result, enrollees are treated with respect, dignity, and old fashioned customer service.

Each CountyCare enrollee membership card gives them access to geographically convenient clinics and a 24-hour hotline. Services offered include office visits, outpatient treatment, hospitalization, prescription drugs, vision, and hearing services and dental care.

We have few cases of enrollees abusing the privilege of the system. Instead, people seem to take advantage of the opportunity to take better care of themselves. We have reduced the average length of hospital stays by 1.1 days and our annual costs have increased by an average of only 1.5 percent. That compares favorably with the annual rate of increase of more than 11 percent for Michigan's Medicaid program.

CountyCare and its current successor, renamed PlusCare, have had positive effects in a wide range of areas. The program has helped the financial health of our hospitals in Wayne County, which have seen a decrease of more than \$100 million a year in unreimbursed cost due largely to decreased emergency room visits. County health care providers have created jobs. Our \$135 million deficit has been eliminated and indigent health care costs are probably less of a concern today than employee health care costs.

Our success with CountyCare has inspired us to attempt a logical expansion of the managed care system into an area of health care for the working poor. Wayne County's health choice program will commence operation this month. In its pilot phase, four health care providers will offer services for up to 8,000 low-wage workers for a single rate of \$108 per person per month.

Before I give brief details of this program, let me explain why we are doing this. There are more than 1 million uninsured persons in the State of Michigan and 150,000 of them are in Wayne County. That is a disturbing figure.

More disturbing is the fact that two-thirds of Michigan's uninsured adults have jobs. Almost 60 percent have high school or college degrees. These people are caught in a trap. They earn too much to be eligible for traditional public sector health care like Medicaid, Medicare and PlusCare, but their low-wage jobs make insurance impossible. One serious illness may mean unemployment and a whole wave of new public costs to support that person.

Wayne County targeted this population with the health choice program. The attractions to employees are obvious. We felt employers would be attracted by the prospect of offering the sort of benefits that would significantly reduce turnover and training costs. A qualifying employer is one who has no health plan for its employees since January 1993, 90 percent or more of its employees must be located at a workplace in Wayne County. The company must employ at least five people and not less than 50 percent of all employees must have an hourly wage of \$10 or less.

Qualifying workers must be without health care benefits and ineligible for Medicare or Medicaid, ineligible for other employer sponsored health care coverage, work an average of 20 hours a week or more, and enjoy an anticipated work future of more than 5 months.

The premium fee structure is one-third employer paid, one-third employee paid, one-third health choice subsidy. Covered services include office visits, outpatient treatment, hospitalization, prescriptions, ambulance services and home care services. Supplemental services can be purchased by enrollees for physical therapy, durable medical equipment, vision, contraceptives and unlimited hospital stays.

HealthChoice is employer driven. You can't sign up for the program unless your employer does. We are currently marketing the program to such employers as fast food outlets, family owned businesses and service industries.

We think HealthChoice is a positive step forward, but it will not solve all the health care problems of Wayne County's uninsured population. Financing, health status and access issues must be addressed at a State and Federal level. At Wayne County, we actively support ongoing efforts to address these problems. We believe our programs can serve as a national demonstration available for duplication in other areas of the country. We have learned a lot about the challenges of serving this population and we look forward to sharing our lessons. Our Congress continues the debate on health care reform.

Wayne County is proud to be in the forefront of change. We are concerned about access to care, especially to urban residents. We endorse universal coverage and applaud the efforts of the administration and Congress to resolve this longstanding problem.

Congress must face up to the challenge. Municipalities have struggled with horrendous financial problems created by unfunded Federal mandates. In the Federal haste to eliminate disproportionate share hospital payments and the Medicaid program itself, municipalities must be protected against increased financial burdens caused by uncompensated care or underfunded initiatives.

We urge that any health care legislation passed by Congress allow local jurisdictions the flexibility and creativity to tailor our solutions to health care problems to local needs. Specifically with respect to establishing regional health care alliances, we ask Congress to consider an option that allows municipalities, such as counties, which meet certain size and demographic requirements, or with significant experience in managing health care, to be qualified by statute for a designation as a regional health care alliance.

Wayne County, with a population larger than 16 States, must be allowed to tailor our programs to the needs of our citizens, employers and government. We should not have to depend on the State of Michigan to design our programs for us. We are prepared to meet specific Federal standards. We need the flexibility to meet those standards with a system that will work in an urban area that bears few resemblances to the rest of our State.

Wayne County supports the public health related improvements in the President's plan. Given Wayne County's large indigent population, the essential community provider provisions of the legislation are also of pivotal importance. The experience and success we have had in and the coalitions we have built with CountyCare, PlusCare and HealthChoice, position Wayne County to serve as a demonstration to the Nation of how to design and operate a managed health care system that works.

We appreciate the opportunity to share our experiences with you and hope we can be of continuing services as this critical debate moves forward.

Thank you.

Chairman STARK. Thank you. In CountyCare or PlusCare, you pay a flat rate of \$80 per month per person. Who do you pay that to?

Mr. McNAMARA. You pay it to a health care provider. There are four health care providers that have bid competitively, and of the 50,000, each one has in the neighborhood of about 12,000 patients or—

Chairman STARK. They provide primary care as well as specialists?

Mr. McNAMARA. Yes.

Chairman STARK. They provide hospitals?

Mr. McNAMARA. They in turn contract with hospitals to provide that service.

Chairman STARK. And there is no cost to the county?

Mr. McNAMARA. The county puts \$15.5 million in the program each year.

Chairman STARK. \$15 million?

Mr. McNAMARA. Yes, but we know that it is costing us \$15 million. Seven years ago, it was costing us \$22 million.

Chairman STARK. So about \$300 a head of county resources in addition to about \$1,000 that you pay, no other costs. So you are averaging \$1,300.

Mr. McNAMARA. It is roughly \$1,000 per year per capitated person in the program.

Chairman STARK. That is the \$80 you pay.

Mr. McNAMARA. Yes.

Chairman STARK. What about the \$15 million?

Mr. McNAMARA. Mr. Chairman, the \$15 million is a part of the total cost of the program. We put \$15 million in. The Federal Government puts—matches a portion of that. The State puts \$7.5 million in for a total of about \$51 million.

Chairman STARK. \$51 million?

Mr. McNAMARA. Of that—that is correct. We serve almost 50,000 people.

Chairman STARK. So that is where you get your \$1,000?

Mr. McNAMARA. Yes.

Chairman STARK. That is what I couldn't quite add up.

How are you doing in your new plan, HealthChoice? As I read it, if the employer decides he doesn't want to spend any money, you can't get in. In other words, the employer has to participate.

Mr. McNAMARA. That is correct. It is employer driven. We have several very interested employers, such as Little Caesar's, and I think what they see is a program that permits them to keep employees that might otherwise leave the employ and go on to a—

Chairman STARK. How long have you had the enrollment open in this?

Mr. McNAMARA. It has been open about 30 days and we have about seven prospects. Again, the people that are going to sell this program are the health care providers that we have designated to go out and search out—

Chairman STARK. I will tell you what is happening in California. I can't compare the plans, but the State has got some kind of a new HIPC for the same population. If there are 35,000 enrollees now and only 3,500 of them are previously uninsured, the rest of them are all just employers who switched to this plan because it is cheaper, and I at that rate, we figure it will take about 83 years for California to cover its uninsured, but I hope you have better luck than we are having in California.

I am—a bit of nostalgia here. Jim, as you know, I was born in what is now Mount Sinai and had my tonsils out in Mr. Vice's hospital, and was a member—auxiliary member I suspect—of the Camelia or Azalea branch, whatever those things were in Children's Hospital 1,000 years ago, although I am not sure I did my fair share, and I welcome these hospitals here.

I would ask Dr. Staggars and Mr. Vice that, you are worried about this essential community designation, but that is only critical if we have managed competition approaches, isn't it? You get paid under Medicare and Medicaid now. You don't need any special designation, right?

Mr. VICE. I guess my comments are we get paid under Medicaid now.

Chairman STARK. I am not talking about the amount. I am just saying if you don't get into managed competition, you aren't going to get paid any more by Aetna than you do by Medicaid. Don't hold your breath.

Dr. Staggars, same thing is true for you. If we go on with the insurance and the reimbursement systems as they are, you don't have to be designated anything.

Ms. STAGGERS. Well, I am not sure that is—our experience has been that there is still this whole issue of nonpediatric hospitals, the adult facilities being able to take as good care of children as children's hospitals can. Same with private insurance companies, the issue has come up, so I am not sure it has to do—

Chairman STARK. Private. It doesn't come up with Medi-Cal or Medicare.

Ms. STAGGERS. With the whole managed care movement—

Chairman STARK. That is what I am saying. If you get managed care out of here, you don't have any problem. Blue Cross pays you, right?

Ms. STAGGERS. Theoretically, you are right.

Chairman STARK. Medicare pays you, Medi-Cal pays you.

Ms. STAGGERS. That is true.

Chairman STARK. I am not going to argue about the rates with Mr. Vice either. Kaiser doesn't pay you, or very seldom, right?

Ms. STAGGERS. Right.

Chairman STARK. And I don't know who you get as a big HMO in Milwaukee, but they aren't coming to you very often, I would imagine, either, are they?

Mr. VICE. We see more and more of them in negotiating. Get us all back to managed care. If managed care is not there, it won't be as bad.

Chairman STARK. That is what I wanted to hear. Let's have that answer again for the record. If managed care isn't there, it what?

Mr. VICE. Won't be as bad.

Chairman STARK. All right. That is what I thought you wanted to say.

I don't know. Mr. Goldsmith, you anticipate some losses. Do you think that those will mostly come from that reduction in the disproportionate share adjustment?

Mr. GOLDSMITH. Well, we are looking at all the reductions, the Med Ed reductions, the dis-share reductions really across the board, and they are obviously very substantial and hit our members very, very hard.

Chairman STARK. Jim, you give us a pretty graphic picture of the neighborhood around the area in which Mount Sinai exists, and it still has an emergency room, right?

Mr. MOODY. It does.

Chairman STARK. The only other place is County Hospital way out for the next emergency room going west?

Mr. MOODY. Well, there are—Columbia and St. Mary's have emergency facilities, too, on the east side. There is a very well-known burn center in St. Mary's, for example.

Chairman STARK. St. Mary's on North Avenue, right by the waterfront?

Mr. MOODY. Right, exactly.

Chairman STARK. Then you go to the south side.

Mr. MOODY. On the south side, there are several.

Mr. VICE. I have got to add, Mr. Chairman, we work with Sinai and actually run an urgent care clinic in the evenings and weekends adjacent to their ER so we can help them with the children there.

Chairman STARK. I don't know what kind of managed care groups you have showing up in Milwaukee. I am more familiar with Dr. Staggers. It isn't so bad. I just don't know how many of them actually refer to Children's. I doubt if Kaiser does. In our county, half the people belong to Kaiser, half.

Ms. STAGGERS. Yes.

Chairman STARK. So you are dealing with the other half of the people, and I don't suppose anybody else has the hospital resources.

Ms. STAGGERS. No, but—

Chairman STARK. They own. So you get your crack at the other half of the kids.

Ms. STAGGERS. Right, but there is some Kaiser crossover. As I said, since I am in adolescent medicine, if you don't want to be seen because your parents are at Kaiser, your family is at Kaiser, you would come into Medi-Cal and see us.

Chairman STARK. Is that the Medi-Cal rule? You have just got to be under 18?

Ms. STAGGERS. It is 12 to 18 for confidential services.

Chairman STARK. That is good. Jim, I wish you were still here to help us get this problem worked out.

Mr. MOODY. Thank you very much.

Chairman STARK. We are going to have a tough time. I think that the hospitals that you all represent are ones that we will—insofar as this subcommittee is concerned—do our best to see that you continue to get funded. I think you will have better luck with us than you will with Prudential, but you can take your choice, and like my friends in the previous panel who decided to endorse the

President's plan, I wish them a lot of luck, but I think if they will think it over, they have had better luck with this committee than they are ever going to get out of the Jackson Hole group. Of course, it is a free country and you can take your choice.

Mr. McNamara has decided to do it on his own and not wait. I presume that you wouldn't like a mandatory alliance forced on the State of Michigan because then you would have to comply with that and you would just as soon have the flexibility to work out programs that work best for Wayne County, is that your—

Mr. McNAMARA. Well, obviously we believe that health care should be there for everyone, whether they like it or not, but certainly we would like to work them out. We think that if the user does have some input in the form of contribution, it is going to be a more effective plan and it is probably going to be a little more cost contained than some of the Blue Cross plans that are out there floating around today.

Chairman STARK. Do you still have to operate a county hospital, a municipal hospital?

Mr. McNAMARA. We sold it 7 years ago. We have the medical center that is made up of numerous hospitals that are part of this program and benefit from it.

Chairman STARK. I want to thank you all for your assistance. I hope that whatever we do the next month or so, I am quite sure it will take care of the concerns that you represent. Whether we can hang on to that as we wind through the procession of the other committees and the other body is another question. But we will try and we appreciate your assistance here today.

Thank you very much. The committee is adjourned.

[Whereupon, at 5:30 p.m., the hearing was adjourned.]

[Submissions for the record follow.]

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Chairman Pete Stark
Subcommittee on Health
House Ways and Means Committee
1114 Longworth House Office Building
Washington, D.C. 20515

Attention: Janice Mays and Tricia Neuman

RE: Health Care Reform and American Indian/
Alaska Native Populations: The
Federal Obligation to Preserve
and Enhance Indian Health Programs

Dear Chairman Stark:

We have participated in numerous National Indian Health Care Reform meetings and discussions in the past 12 months. We have also reviewed the National Congress of American Indian (NCAI) December 3, 1993, resolutions regarding health care reform, and January 31, 1994, testimony of NCAI and the National Indian Health Board before the Senate Committee on Indian Affairs. While we are writing specifically in behalf of our low-income American Indian clients, we are confident that our views are largely shared by national Indian leaders.

We ask that the following comments be added to the record of your January 31, 1994, hearing on Health Care Reform and Urban and Rural Populations. This letter discusses the unique and overriding obligation of the federal government has to promote and enhance the Indian health care delivery systems and several important Indian issues which we believe would arise under your proposal (as we understand it) to join Medicaid with Medicare into a new federal program.

The Federal Government Is Obligated To Enhance Indian Health Programs

The Administration's Health Security Act, H.R. 3600, expressly acknowledges the unique status of Indian health programs, but further reduces funding to already underfunded Indian health programs and otherwise weakens the Indian health care delivery system. Other health care reform bills have no language describing Indian health programs' interrelationship with new health care delivery systems. We are greatly concerned that no federal proposal for health care reform has adequately recognized the federal government's moral and legal obligations to provide health care for Indians and Alaska Natives.

The federal government's unique obligation to provide health services to American Indians and Alaska Natives should not be jeopardized by including the Indian health care in either one national health care reform plan or in a separate plan for rural and urban populations, without consideration of the legal, moral, and cultural reasons for maintaining a separate, strong Indian health care system. Nor should health care reform be used to further cut back resources to Indian health programs which are already greatly underfunded.

Congress and the federal courts have protected the sovereignty of Indian tribes for 170 years. Congressional statutes and appropriations have been used to provide health care for Indian people even longer. The promise of health care was a major element of the treaty negotiations of the last century, in which Indian tribes ceded vast tracts of land to the federal government and non-Indian settlers. Senator Inouye calls health services to Indian people "the nation's first prepaid health plan."

The Indian Health Care Improvement Act of 1976 was Congress' first attempt to codify the broad scope of the federal obligation to provide health care to Indian people. It does not repeal or replace the earlier treaties or congressional declarations. The 1976 statute does provide a useful definition of the federal government's obligation to provide Indian health care, which should not be overlooked during the current health care reform debate:

(a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal government's historical and legal relationship with, and resulting responsibility to, the American Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum

participation of Indians in the planning and management of those services.

. . .

25 U.S.C. §1601

The federal government has committed itself to providing localized, culturally appropriate health services to Indian people and to assuring that the services are increasingly provided by Indian

professionals and, at the tribe's option, through Indian-controlled programs. While inadequate funding has been a chronic problem, not until the current health care reform debate has the federal government ever wavered in its support for independent Indian health programs.

The importance of culturally-appropriate health services for Indian people, especially for the many of our clients who are elderly, cannot be overemphasized. They need health services which are based in their community and where Indian culture is understood and respected. Many tribal elders need interpreters for languages that are unwritten. Fluent English is spoken by relatively few. It is not fair to them to be forced to turn to health care providers who do not possess the deep and broad sensitivity of existing Indian health programs.

Indian Health Programs Need Better Access To Federal Medicaid and Medicare Funds

Indian medical services through IHS are limited by very inadequate budgets. To stretch its limited budget, IHS has declared itself to be a "payor of last resort." This unpopular policy requires Indian health programs to look first at Medicaid, Medicare, and private insurance reimbursements before spending IHS funds for medical services.

Because of the "payor of last resort" rule, Indian programs are very affected by Medicare and Medicaid reimbursement rates and by the relationship of the federal government to state Medicaid programs. Your Subcommittee's Medicaid and Medicare proposals could provide badly needed increased revenue to Indian health programs.

As we understand your proposal, Medicaid, except for long-term care, would become a fully-federal program and would be folded into a new program possibly called Medicare Part C. We can see two potential improvements for Indian health programs:

(1) Reduction of State Involvement in Medicaid

If Indian health program must depend on Medicaid revenues then the Medicaid monies should be more accessible. Presently Indian patients must apply separately to the state Medicaid program and to IHS for coverage of medical expenses incurred outside of Indian health facilities. Development of a single IHS Medicaid application/screening instrument has long been needed for use by Indian programs, but remains unfeasible if 50 different state

Medicaid eligibility standards are involved, as present. A single federal Medicaid/Medicare program would be in a much better position to coordinate health coverage with Indian health programs than are the 50 states.

A second major problem that arise with state Medicaid is the requirement of a state percentage Medicaid contribution. Because the states do contribute to Medicaid costs, tribal programs must have state consent to access Medicaid monies. The federal Medicaid statutes allow 100% Medicaid reimbursement for medical services performed at an *Indian Health Service facility*, but the same full reimbursement rates do not apply to tribally-funded health facilities. 42 U.S.C. §1396d(b). Thus most tribes may only access Medicaid under state guidelines.

While some tribes have the technical resources and/or a political relationship with their state which allow them to work out acceptable agreements regarding access to Medicaid monies, most tribes do not. Again, we believe a chance to deal directly with a single, federal program on reimbursements or direct funding for Medicaid-type services would be a great improvement for most Indian health programs. The higher federal rate of reimbursement would also benefit Indian programs (state reimbursement under Medicaid is usually lower).

(2) Greater Access to Medicare Funding

We hope that health care reform will also give Indian health programs better access to Medicare resources. The present system of Home Health Care Agencies, for example, is too highly regulated and expensive for Indian tribes (even the largest, the Navajo Nation) to administer. Further, Indian programs without IHS hospitals or facilities are not eligible for Medicare reimbursements at all. We hope, in developing a proposal for a Medicare/Medicaid combined program, that the final program funding would be much more reasonably accessible to Indian health programs.

Health Care Reform or Wrap-around Coverage Should Not Be Paid for from Existing or Future Indian Health Service Budgets


Indian Health Programs need assurance that federal funding for any standard benefit package or wrap-around benefit package will not diminish the Indian Health Service Supplementary Benefit appropriations. One of the distinguishing features of Indian health programs is its own type of wrap-around services which have developed in response to the unique legal status and unusual health problems of Indian people. For example, IHS has a highly developed

public health delivery system with a heavy emphasis on preventative health care, and a safe water and sewage program that funds well digging and installation of septic tanks in rural areas.

Tribal leaders are greatly concerned that existing and future funding for IHS supplementary services will be diverted to cover an expansive standard medical benefit package under health care reform. Funding for health care reform should increase services to Indian health consumers so that existing IHS funding can be used to finally meet its obligation to provide the IHS supplementary services package. One example of current underfunding: the IHS sanitation program is presently underfunded by \$1.64 billion, IHS has budgeted only \$600 million over the course of a 10 year plan to meet this critical need, and the Administration has requested no sanitation funding in its FY 95 IHS budget. If additional federal money is available to pay for present IHS medical services under health care reform, then IHS should be better able to more adequately fund its existing supplemental benefit programs.

We hope that you include Indian leaders and Indian organizations in your discussions of health care reform. Please call us if we can provide more information, or contact Gordon Belcourt, Executive Director of the National Indian Health Board (303-759-3075), or Rachel Joseph of the National Congress of American Indians (202-546-9404). All Indian leaders are greatly concerned that American Indian and Alaska Native health care needs are not being given adequate consideration in the national debate over health care reform. We would be happy to work with your Subcommittee to help ensure that its proposals enhance present Indian health care delivery systems.

Very truly yours,


M. Helen Spencer
Evergreen Legal Services
Native American Program with

Thomas N. Termaine
Spokane Legal Services,

Steven C. Moore
Native American Rights Fund
Support Center

cc: National Congress of American Indians
National Indian Health Board

STATEMENT OF GEISINGER FOUNDATION

The Geisinger Health Care System ("Geisinger") wishes to provide this written statement on the health reform issues relating to rural communities.

Geisinger, as a rural health care system, serves approximately 2,300,000 residents in a 31-county region of central and northeastern Pennsylvania. Geisinger Medical Center is one of four rural referral tertiary-care centers of 500 or more beds in the United States. With its full-time, salaried, multispecialty group practice, it was the basis for the present Geisinger health care system. (Geisinger's organization and service area are described further in Appendix A).

Geisinger's Principles for Health Care Reform –1993

In the spring of 1992, as the current national health care debate was being joined, Geisinger adopted a statement of reform principles (see Appendix B).

In brief, these principles encapsulate the thoughts of Geisinger's management concerning the accessibility, affordability, and accountability of health care, and the place of medical education, research, and public health in the reform debate from a rural health care system perspective.

During this year, Geisinger has been cited three times as a potential model for reformers to follow. (See Appendices C, D and E). That national attention has made us aware of two critical facets of the health care reform debate.

- *First*, a considerable amount of reform is occurring, without government intervention. And Geisinger is among the leaders in that reform movement.
- *Second*, there are specific areas in which federal action can empower and amplify those private efforts.

ACCESSIBILITY

The Geisinger experience shows how a private institution can effectively improve the *accessibility* of health care in a large rural region. Over the past 12 years, Geisinger has established 26 rural medical practices and expanded a number of additional existing practices. That has resulted in the addition of many physicians to our service area — the majority of them specializing in primary care. Geisinger physicians now represent 9.4 percent of primary care physicians in the 31-county area we serve.

Because of Geisinger's charitable charter, Geisinger physicians provide service without regard to ability to pay, which improves accessibility to medical care for all the residents of the area we serve. The declining economic state of rural providers, exacerbated by health reform initiatives, has led to many collaborative discussions on how best to restructure the combined resources of providers to meet the health care needs of the population. Those discussions focus on such issues as : The continuing need for certain rural providers entirely or as "full-service" hospitals; the ability of private, primary-care practitioners to continue in solo practice; and the conversion or establishment of urgent-care centers and other alternative-delivery facilities, including the restructuring of home health services. Home health services represent a delivery alternative that is growing in importance in our rural setting.

But Geisinger currently has 66 vacancies for primary-care physicians. Recruitment in primary care has become increasingly difficult in recent years. Recognizing that we will be unable to recruit, nor possibly afford, all the primary-care physicians we need, Geisinger is emphasizing the necessity of expanding alternative-care providers in support of our clinical programs and is actively considering the development of training programs for such professionals.

Additionally, we will no longer be able to afford or recruit the high level of specialization that has been traditional throughout our workforce. We are studying ways to shift to a broader-based workforce and to alter the work we do in order to downsize and reduce our overall operating costs.

In order to continue, and perhaps to enhance, access to our services, Geisinger has established a technology strategy to link together our provider network for accessing and sharing medical information. Although an appropriate goal, it will be very difficult to accomplish in an environment of declining reimbursement and increased cost-containment.

RECOMMENDED FEDERAL ACTIONS:

Improve the quality of care and the quality of rural practice as a career choice by:

- *Using incentives to increase the number of physicians entering the primary care specialties.*
- *Using incentives to increase the number of primary care physicians who choose rural practice.*
- *Providing assistance to private institutions to develop rural practices.*
- *Supporting public transportation in rural areas, with a focus on increasing access to medical practices.*
- *Supporting research and development of communication and information technology to link rural generalists with specialty centers.*
- *Provide demonstration-project funding for hospital facility conversions to alternative-care facilities associated with health care networks.*
- *Use incentives to enhance the alternative-care professions and increase the number of such practitioners, especially those willing to locate in rural areas.*

AFFORDABILITY

Geisinger is demonstrating the effectiveness of an integrated health system in improving the *affordability* of health care. Geisinger's health maintenance organization, Geisinger Health Plan, has the lowest premiums of any HMO in Pennsylvania. It has the lowest premium of any HMO option being offered to federal employees in 1993. Yet the Geisinger Health Plan is able to provide high-quality care within a fixed budget and still contribute to the support of Geisinger's charitable, educational and research activities. Geisinger Health Plan now covers approximately 160,000 people and provides one-third of the total support of the Geisinger system.

In response to Geisinger Health Plan's success, we are seeing changes in the rest of the area's health care economy. Competition among providers (the typical medical arms race) is being replaced by competition among systems (in which the most efficient win). Meanwhile, competing health plans are moderating their premium increases and improving their managed care operations.

Employers in the area we serve are actively fostering competition by favoring the low-priced options in their employee health-benefit plans. They are already creating "managed competition" on their own.

Thus, directly and indirectly, Geisinger is having a positive impact on the affordability of care.

RECOMMENDED FEDERAL ACTIONS:

- *Encourage the states to develop managed competition at the state and local level: allow waiver of the "ERISA preemption" of state laws pertaining to employee health benefits.*
- *Protect the access of non-profit institutions to low-cost capital by clarifying the criteria for charitable tax exemption (Section 501(c)(3)), to include health plans and other non-profit components of integrated systems engaged in the support and advancement of federal health policy.*
- *Encourage efficient integrated systems to enroll Medicare and Medicaid beneficiaries. That would include further improvement of the risk contract payment methodology (the AAPCC), and legislation to permit HMOs to function as medicare supplemental plans.*
- *Reduce the administrative costs associated with health care through an expanded use of communications technology such as Electronic Data Interchange (EDI).*

ACCOUNTABILITY

Geisinger has come to view *accountability* as more than periodic accreditation, even as accreditation and licensing requirements continue to be among our most important public accountabilities.

In the past year, one of our hospitals placed in the top ten percent of national reviews by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Geisinger Health Plan voluntarily went beyond the requirements of Pennsylvania law for external quality review, and applied for full accreditation by the National Committee on Quality Assurance (the HMO industry's accreditation body).

Beyond accreditation, we are working with a major corporate client to design a scorecard of quantitative and qualitative measures demonstrating quality and quality improvement to that employer.

Geisinger conducts formal, statistically significant patient surveys. We monitor the technical quality of care in a variety of ways; to do so, in fact, we conducted more than 400 studies last year. We track patient complaints and concerns, and we report them for management response. Results are considered major management accountabilities, and Geisinger's group practice structure makes our physicians continuously accountable to their peers in the group.

In general, however, the threat of litigation impedes public accountability for quality improvement in the health care industry, in the event that peer review data are made public.

RECOMMENDED FEDERAL ACTION:

- *Increase the willingness of health care institutions to publish comparative information about quality; enact a more equitable approach to identifying medical malpractice and compensating patients.*

EDUCATION

Geisinger's support for *education* dates from our earliest days. Since our founding, we have trained more than 2,400 interns, residents and fellows, graduated more than 3,200 registered nurses, and developed training programs in nine allied health professions. Total registration for the 1993 - 1994 school year was 181 resident physicians, 16 graduate fellows, 190 nursing students, and 72 students in allied technologies. Many of those students will remain in rural service when they complete their training.

Geisinger operates nine schools of allied health education:

- Cardiovascular Technology
- Dietetic Internship
- Histotechnology
- Medical Technology
- Nurse Anesthesia
- Nursing (diploma program)
- Radiation Therapy Technology
- Radiographic Technology
- Pastoral Care

Increased competition, however, will reduce the ability of medical institutions to subsidize the cost of education from patient revenues.

RECOMMENDED FEDERAL ACTION:

- *Provide direct support for educational programs, especially those that advance federal policy, such as primary care and rural practice.*

RESEARCH

Geisinger operates an \$9 million basic science research program. Of that, nearly \$4 million is supported by grant funding and endowment. Geisinger supports 11 full-time scientists and 408 separate research projects.

In addition, Geisinger has also begun research in health services and outcomes. The first project, measuring the short-term savings and health improvement from smoking cessation, has already produced encouraging data. We have seen a high cessation rate and nearly immediate savings from the reduced use of medical services among those who have successfully quit.

RECOMMENDED FEDERAL ACTION:

- *Increase support for outcomes research, especially in the setting of integrated health systems.*
- *Support methods to rapidly disseminate results of outcomes research.*

PUBLIC HEALTH

The medical community's interest in *public health* concerns has faded in prominence with the improvements in sanitation, immunization and treatment of disease that have characterized the second half of this century. Over the years, Geisinger, like most institutions, had adopted a reactive posture in public health matters. We are a major source of care for accident and illness for much of our area. We are the place to go if a man, woman or child is sick, and especially if that man, woman, or child is sick *and* uninsured.

Geisinger employees, often acting on their own initiative, have continued a long tradition of voluntary public education about hygiene and safety in the communities we serve. Now, as an institution, we have come to recognize again the need to specifically incorporate a public health role in our business plans, and to support, encourage, and recognize the individual initiatives among our employees.

RECOMMENDED FEDERAL ACTIONS:

- *Provide support and recognition for health care institutions that adopt active public health agendas. Look to the nation's emerging integrated health systems as logical allies of federal and state agencies in identifying and ameliorating public health hazards.*
- *Support a public-private partnership to greatly improve the level of public knowledge about disease prevention, diet, exercise, safety, stress management, and the risks of chemical abuse.*

SUMMARY

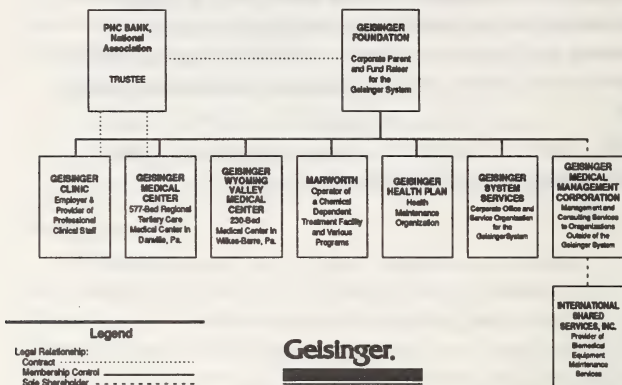
In summary, the past few years have seen most of the components of proposed national health care reform develop in the private sector. Geisinger is a practical example. Managed care, managed competition, public accountability, access improvements: all can be found to some extent in various sections of the nation. The time is ripe for federal action to encourage the growth and spread of those developing systems.

While major reform is being debated, *we suggest a package of more modest reforms to continue that significant private sector activity.*

APPENDIX A

GEISINGER. HEALTH CARE SYSTEM

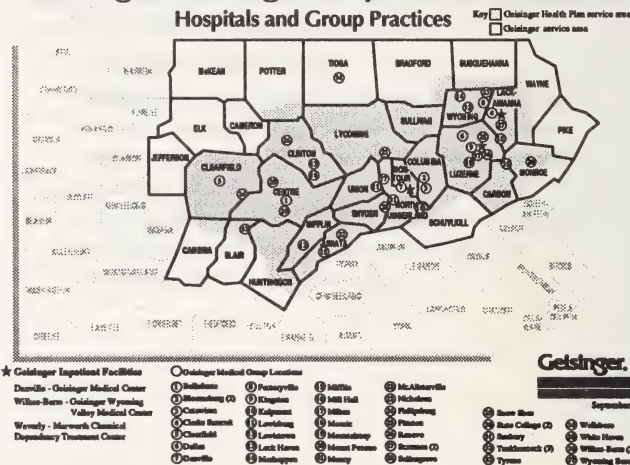
Corporate Structure



* - Geisinger is a registered service mark of Geisinger Foundation for operating medical, nursing and other health care educational programs through a multi-institutional health care system. Throughout this document, the term Geisinger refers to the entire system of health care comprised of Geisinger Foundation and all corporate entities affiliated with or controlled by Geisinger Foundation.

Geisinger — A Regional System of Health Care

Hospitals and Group Practices



Mission Statement

The Geisinger health care system serves more than 2.3 million Pennsylvanians across 31 primarily rural counties, from the state's northeastern corner to its midpoint — and thousands of others through widely distributed outreach programs. That broad focus is consistent with the Geisinger mission:

To improve the health of the people of the Commonwealth through an integrated system of health services based on a balanced program of patient care, education and research.

Geisinger's primary values are enumerated as a commitment to constancy of purpose, continuous improvement, people caring, teamwork, tradition and financial stability. The *New York Times*, in a front-page article on March 18, 1993, applauded Geisinger's integration of its medical and administrative staffs in ways that contribute to cost-effective medical care.

The character of Geisinger health care management is recognized nationally. The National Committee for Quality Health Care last September offered the Geisinger approach as one of several national models for reforming American health care. The Geisinger management style integrates continuous formal planning and problem-solving methods with day-to-day control systems that assure efficient operating performance.

Geisinger's four driving corporate strategies are articulated succinctly this way:

- Geisinger functions as *one* organization.
- Clinical programs and clinical process improvements size and drive the Geisinger system.
- Managed care is Geisinger's primary business strategy.
- Geisinger seeks collaborative opportunities to increase access to cost-effective services.

Geisinger is focusing on its managed-care system, replacing fee-for-service business with capitated populations. That strategy will permit an even more effective management of limited resources, offer greater value to central and northeastern Pennsylvania consumers, and position Geisinger as the provider of choice in its region.

GEISINGER'S HISTORY

Crucial to the Geisinger concept of managed care is Geisinger Health Plan (GHP), which now has approximately 160,000 members. Founded in 1972 as one of the first rural health maintenance organizations in the United States, GHP is now the nation's largest rural HMO. The Geisinger Clinic's approximately 520 employed physicians offer GHP services at 45 primary care locations and 13 community hospitals in all or parts of 25 Pennsylvania counties. And, also through the Geisinger Clinic, GHP has agreements with 433 privately practicing physicians in central and northeastern Pennsylvania to deliver services complementing those that Geisinger specialists offer. GHP enrolled its 500th employer group during the past year.

Geisinger has introduced a variety of strategies to strengthen and improve its operational performance. Those strategies were aimed at sizing our system to respond to changes in the healthcare environment, and they included a system-wide workforce reduction.

A resiliently adaptive frame of mind is ingrained in the Geisinger approach to health care. Throughout its history, in fact, Geisinger has been a consistent example of the efficiency, effectiveness, and flexibility of medical group practice. The Geisinger group practice has changed in form and function over the years to respond to changing socioeconomic environments, but it has not deviated from the intent of its founder, Abigail A. Geisinger. Nearly 72 years after her passing, this organization retains Mrs. Geisinger's commitment of service to mankind.

History and Development

Founded in 1915 as the George F. Geisinger Memorial Hospital, Mrs. Geisinger's gift to her community in memory of her husband, the hospital was designed as a comprehensive regional health care institution that would offer specialized services to people in rural areas.

Harold Foss, M.D., was Geisinger's first chief of staff, and he served in that capacity from 1915 until 1958. Trained at the Mayo Clinic, Dr. Foss advocated the group practice of medicine and hired specialty-trained physicians who formed the full-time, salaried, closed staff of the hospital. The original hospital of 70 beds has grown to be one of the nation's four largest and most modern rural medical centers and now has 577 beds.

In 1961 the George F. Geisinger Memorial Hospital became Geisinger Medical Center. Twenty years later, in 1981, Geisinger Medical Center and its affiliates underwent a corporate reorganization and became a system of health care delivering medical and health-related services under the common control and direction of Geisinger Foundation.

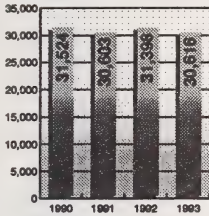
A Geisinger Overview

- Approximately 520 physicians provide the excellence of Geisinger healthcare throughout central and northeastern Pennsylvania. Some of those physicians practice in small family health centers and some in large medical groups. Wherever they practice, they have access to hundreds of support services provided by the entire Geisinger system.
- Geisinger has two hospitals. Its 577-bed *Geisinger Medical Center* in Danville delivers specialized care—emergency medicine, cardiovascular surgery, newborn intensive care—actually 75 specialties and subspecialties in all. Geisinger Medical Center operates two medical helicopters, provides comprehensive trauma care 24 hours a day, and conducts outreach, educational and research programs in trauma care. The medical center is also home for the Janet Weis Children's Hospital, now under construction and scheduled for completion in 1994. Its other specialized care centers focus on kidney, neurosciences, trauma, heart, cancer, and infertility treatment. *Geisinger Wyoming Valley Medical Center* in Wilkes-Barre is a 230-bed secondary referral center serving as the eastern hub of the Geisinger system. Geisinger Wyoming Valley Medical Center cares for patients in the Greater Wyoming Valley and western Pocono region with comprehensive maternity programs and pediatric services, five medical/surgical units, the new Frank M. and Dorothea Henry Cancer Center, and a complete emergency department. Geisinger Wyoming Valley Medical Center also offers an extensive community-health education program.
- The Geisinger program for alcohol and chemical detoxification and rehabilitation is system wide. It includes the 56-bed Marworth inpatient treatment center in Waverly, Pennsylvania, which addresses the physical, social, psychological and family issues of dependency and recovery and coordinates outpatient chemical dependency services wherever Geisinger provides health care.

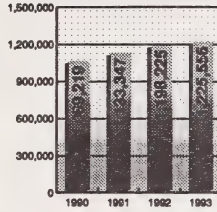
-
- Geisinger's health maintenance organization, GHP, offers members a variety of medical services for a flat fee. Medical expenses such as hospital and doctor bills are pre-paid under the plan, as are routine check-ups, immunizations, well-child care, and inoculations.
 - ISS, a Geisinger affiliate in Plymouth Meeting, Pennsylvania, has responded to the requirements of the Joint Commission on the Accreditation of Health Care Organizations by offering hospitals clinical technology-management programs that can improve the quality of patient care while reducing hospital costs. ISS is one of the nation's largest independent clinical engineering firms. It has served hospitals and clinics throughout the mid-Atlantic region since 1972 and now has more than 160 corporate clients.
 - Geisinger Foundation serves as the parent organization for the Geisinger system, which also includes Geisinger System Services and the Geisinger Medical Management Corporation. Geisinger Foundation coordinates fundraising, manages telethons, and facilitates community services.

1993 FISCAL YEAR

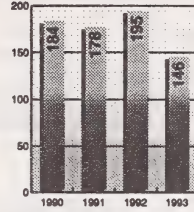
Admissions



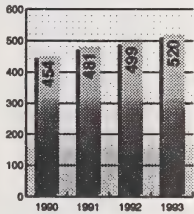
Clinic Visits



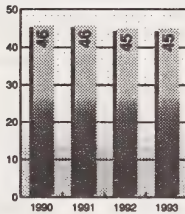
CME Programs



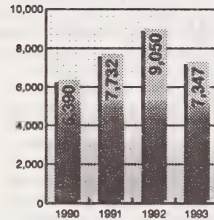
Number of Physicians



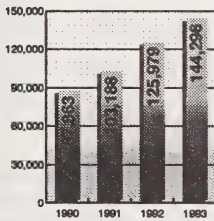
Number of Clinic Sites



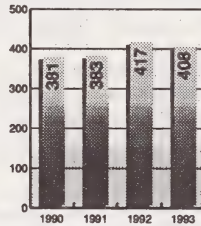
CME Attendance



GHP Members



Active Research Projects



**all figures as of June 30, 1993*

1993 FISCAL YEAR

GEISINGER STATISTICAL SUMMARY

(for fiscal year ending 6/30/93, except where noted)

Patients

GHP Enrollment (as of 10/31/93)	149,193
Outpatient Visits	1,225,556
Hospital Admissions (including newborns)	30,616
Life Flight Helicopter Retrievals	1,236

Employees

Physicians	520
Physicians in Training	207
Employees (including physicians and physicians in training)	7,301

Education

Residency Programs	15
Fellowship Programs	6
Medical Education Programs	146
Medical Education Participants	7,347

Research

Research Expenditures	\$9,215,000
Research Projects	408

Financial Indicators

Total Revenue	\$786,564,000
(including operating and nonoperating revenues)	
Allowances	278,245,000
(to insurers, government, third-parties, charity care, and uncollectible accounts)	
Total expenses	<u>480,649,000</u>
Funds Available for Reinvestment	27,670,000
Less Transitional Obligation	(14,683,000)
Less Loss on Defeasance	<u>(2,273,000)</u>
Total Funds for Reinvestment	<u>\$ 10,714,000</u>
Public Support	<u>\$ 8,259,000*</u>
(includes gifts and grants, plus revenue associated with the Children's Miracle Network Telethon)	
Charity Care, Policy Deductions,	<u>\$ 12,040,000*</u>
Uncompensated Care	<u> </u>

* included in the totals listed above

Geisinger's Principles for Health Care Reform

Introduction

Government is a partner in the health care system.

Over time, the cost of this partnership has far exceeded original expectations.

As a result, and in the absence of a coherent federal health care policy, government's decisions about health care have been budget-driven, not program-driven.

This budget-driven approach has created conflicting incentives between patients and health care providers, and access issues for the uninsured and underinsured. Health care policy reform is key to the improvement of our nation's health care system.

Integrated regional systems of health care, like Geisinger, have a vital role to play in the delivery of health care and health care policy reform.

A national consensus on health care reform is yet to emerge. However, while no single proposal can claim majority support, we believe certain basic principles are already held in common. These principles, in turn, can serve as a framework to guide the design and construction of the actual components of reform.

Central to reform are the **accessibility, affordability, and accountability** of health care services. In addition, to be comprehensive, reform must also address **medical education, research, and public health**.

Health care must be accessible. Effective reform must remove barriers posed by cost and geography.

- A basic set of essential services must be available to anyone, without regard to medical history, employment status, or ability to pay.

- These basic services must be physically accessible in the urban core and the rural counties, as well as the populous suburbs.

Health care must be affordable. The cost of care, both to society and to the individual, must be within our means.

- Integrated regional systems which combine the financing and delivery of health care in a single economic unit offer the best mechanism to reward efficiency and penalize waste. Whether HMO's, PPO's or managed care networks, the formation and growth of such systems should be actively encouraged.

- In the long term, a competitive marketplace is the only effective means to control cost. Price controls and global budgets, unless created with perfect wisdom, produce perverse incentives and shortages. This is demonstrably true in any industry, including health care.

- Competition must be among integrated systems, competing in the private sector on the basis of quality and cost. Competition on quality alone has produced excess capacity. Competition on cost alone has produced inadequate coverage and exclusion of individuals with pre-existing conditions among insurers. Lack of competition rewards unnecessary procedures and duplicative services.

- There must be adequate financing, both public and private, to ensure that no one is excluded from the marketplace by personal financial circumstances. The affordability of the basic set of services must be assured. In addition, individuals or groups wishing to purchase additional services or coverage should be free to do so.

- The market price for the basic set of benefits must reflect true cost. Hidden subsidies, pricing by regulation, and cost shifting must be eliminated for the market to function. Tax subsidies should be limited to the cost of the set of uniform basic benefits. State mandated benefit levels above the basic set of benefits should be eliminated.

Health care must be accountable. To ensure a fair marketplace, the integrated regional systems providing patient care must be publicly accountable for the cost and quality of their services. The marketplace itself must be accountable for its structure and operation.

- Integrated regional health care systems should demonstrate the ability to measure and improve the quality of care, as a condition of participation in the competitive marketplace.

- Tort reform, to encourage rather than impede public accountability for quality, is a necessary corollary.

- To permit comparison among competing systems, all participants in the marketplace must offer, at a minimum, a uniform basic set of essential services.

- Establishment and modification of the basic set of essential services must, itself, be an accountable process. It must be directed to promote the general welfare, not secure private interests. Experimental procedures should be included only upon demonstrated efficacy.

Medical education must be supported and directed. Medical education should be financed and managed to produce an appropriate distribution of personnel among professions, specialties and localities, based upon anticipated public need.

Medical research must receive adequate support and direction. In addition to advancing the scientific frontier, medical research must focus on improving the quality and efficiency of current technology. Research should focus on practice guidelines to identify the best approach from among competing opinions and techniques. Research funding should be separate from patient care financing.

Public health must be reinvigorated. Improved control of preventable diseases and conditions could dramatically reduce the cost of patient care, while permitting the redirection of resources to improve both accessibility and quality.

- Public education in health promotion and disease prevention should be greatly expanded. The message needs to be carried beyond our schools, into workplaces, shopping malls, and homes.

- Public law and public funds must be dedicated to produce further reductions in environmental risks.

- Pressing public health needs must be given greater prominence in medical education and medical research.

- The health care system must educate patients to assume additional responsibility for their own health through healthier life-styles and participation in medical treatment decisions.

Geisinger.

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If you would like further
information about the
Geisinger health care
system, please write:

Geisinger
100 North Academy Ave.,
Danville, PA 17822-3013

The New York Times

NEW YORK, THURSDAY, MARCH 18, 1993

Doctors Say They Can Save Lives and Still Save Money

By ERIK ECKHOLM
Special to The New York Times

DANVILLE, Pa. — Dr. James C. Blankenship, a cardiologist with a health-maintenance organization in central Pennsylvania, performs costly, risky procedures in which tubes are pushed to the heart to help find whether coronary vessels are clogged.

In his catheterization laboratory, he studied X-rays revealing a partly blocked artery in a 55-year-old man. "What are the chances this will shut off, causing a heart attack, versus the risks of surgery?" he asked. "The studies differ."

"I'll advise him to watch and wait," said the doctor, whose salary would not be affected one way or the other. "I want to do everything that's necessary, but not too much."

As Americans consider a more frugal medical future, possibly dominated by competing H.M.O.'s or other forms of "managed care" that limit consumer choice, urgent questions are rising about the quality of care and how to protect it. Will people be pushed into health plans staffed by sullen, rushed doctors whose decisions are second-guessed and who are paid extra to scrimp on costly tests and operations?

Room for Judgment

Or will they find sensitive doctors who have no financial incentive to do too much or too little, have ready access to the best technologies and hold down costs by preventing illness and avoiding procedures with little benefit?

Medical experts are scrutinizing better health plans around the country to see how large savings might be gained through efficiency and prudence, not through shortchanging the sick. And the evidence suggests that institutions that foster physicians like Dr. Blankenship and allow them to exercise professional judgment may be in the best position to pursue that goal.

In the case of the 55-year-old man, some doctors would have recommended immediate surgery, but Dr. Blankenship felt sure, based on available science, that a trial period of drug therapy was in his patient's best interest.

At his organization, the Geisinger Foundation in Danville, the decision about how much is enough is left to the doctors. Their cautious style of medicine has held costs well below the national average. Increases here have still averaged 8.6 percent in recent years, though, raising questions about whether the country will be able to tame medical inflation without cutting into the quality of care.

The 530 salaried doctors who work here, and offer care through a prepaid insurance plan, do receive prodding from above. But it involves not constant second-guessing or rewards for scrimping, but rather a steady flow of research news and tips that helps suffuse the institution with an ethic of conservative care.

"Here, we don't police; we trust our doctors," said Dr. Howard G. Hughes, who directs the H.M.O., the Geisinger Health Plan.

In Danville, a town of 6,000 people, Geisinger runs an advanced 577-bed hos-

pital as well as a network of clinics over a wide area of central and northeastern Pennsylvania. Its growing H.M.O. serves 142,000 members, while the same doctors and clinics also provide the same style of care to hundreds of thousands more people covered by government or other insurance.

The doctors insist that their brand of medicine improves on a system laden with incentives to overuse procedures.

And they are saving money. The H.M.O. has the lowest rates in Pennsylvania, according to the state insurance department, with monthly premiums this year of \$109.70 for individuals and \$285.22 for families for a plan covering nearly everything but prescriptions.

But the numbers suggest, too, just how severe the challenge is. The health plan's charges have risen by an average of 8.6 percent a year since 1985, Dr. Hughes said. That is a good record compared with that of most insurers: nationwide, H.M.O. rates grew by an average of 11.7 percent per year from 1986 to 1992, and rates for traditional fee-for-service plans rose annually by 14.2 percent, according to A. Foster Higgins & Company, a consulting firm.

But it remains well above the national goal of steady real spending set by President Clinton. Recent increases have mainly reflected the rising cost of nurses, technicians and other personnel, the soaring price of new drugs and other factors, officials said.

At What Point Will Savings Stop?

Geisinger doctors and administrators, most of them practicing physicians, insist that through steady refinement they can save much more without compromising care. Just how much and how fast, though, no one is sure.

"Price competition doesn't scare me," said Dr. Stuart Heydt, president of the Geisinger Foundation. "If this model can't hold down prices enough, then I'm not sure it can be done in a way that fulfills the medical expectations of society."

While America's medical costs are increased by administrative waste, excess equipment, incentives to use procedures lavishly and outright fraud, in the end

spending mainly reflects the routine decisions of physicians. They decide when a patient needs a \$70 electrocardiogram, when to order a \$100 dollar antibiotic instead of a \$10 one, and when \$40,000 bypass surgery is truly likely to improve a patient's chances of survival or quality of life.

"The best way to control costs and preserve quality is to have the physicians do it," said Dr. Arnold S. Relman, the former editor of *The New England Journal of Medicine*. "The whole health-care system is built on the behavior of doctors, and that behavior is greatly influenced by the way health care is organized."

Dr. Relman, who has been studying health plans around the country, praised Geisinger for high doctor morale and a system of mutual review that promotes excellent care.

While no organizational structure guarantees quality care, Geisinger has several traits that promote it. The bedrock, officials here say, is the careful selection of doctors who share the group philosophy and are happy to work for a salary. Since they are not paid piecemeal, they make decisions with no direct financial interest at stake. (Nationally, doctors are salaried in some but not all H.M.O.'s or other forms of managed care.)

The salaries here are enough to support an affluent life in this rural region, but for many doctors they are well below potential earnings in private practice. Primary-care doctors have starting salaries in the range of \$75,000 to \$90,000, while among the most experienced specialists who might earn several times as much elsewhere, "very few go beyond \$300,000," said Dr. Laurence H. Beck, senior vice president charged with improving efficiency and quality.

Morale rests on the pleasures of patient care, collaboration, teaching and research, said Dr. Francis J. Menapace, the director of cardiology. "We look for a different type of physician, one who still looks at medicine as a profession, not a business."

Less Reliance On the Specialists

As in most H.M.O.'s, all patients must choose a primary-care physician in the plan. Usually trained in family practice, internal medicine or pediatrics, these doctors provide most care and refer sicker patients to specialists only when necessary, holding down costs.

Now about 30 percent of the plan's doctors provide primary care, but studies suggest the proportion should rise to close to 50 percent, Dr. Beck said. This means cutting back on specialties, a painful and controversial topic among the medical staff.

Dr. Ernest W. Campbell, a primary-care physician and head of the Geisinger clinic in the nearby town of Bloomsburg, had been in independent practice for 18 years before he and his partner decided to join the salaried group in 1985.

"We looked at the H.M.O. and liked what they were saying," he said. "It's more geared toward preventive medicine, keeping people healthy rather than just meeting the acute needs as they arise." He said the switch involved a significant loss in income, but offsetting this was a drop in work time to 60 to 70 hours a week so he could see his family more.

Far from feeling pressure to avoid needed care, Dr. Campbell said, "I think the quality if anything has gone up." Since patients are in a prepaid plan, he said, "now we can tell them they have no excuse for not coming in when they are ill."

A large unified system like Geisinger's can also avoid duplication of costly equipment and readily monitor its use. For example, all cardiac catheterizations, which are Dr. Blankenship's diagnostic specialty and require a million-dollar laboratory, are performed at the main hospital in Danville, as is open-heart surgery. This does mean, though, that some patients have to travel up to 100 miles for major procedures that in a less efficient system might be available at a community hospital.

With central control, too, can come imbalances in staffing, sometimes yielding long waits for non-urgent appointments. Currently, for example, because of a shortage of gynecologists in the group, an appointment for a routine pelvic checkup can take several months. Officials insist that is a temporary side effect of rapid growth and a national shortage, not a long-term shortchanging of patients.

But in surveys of H.M.O. patients that generally find high satisfaction with care and doctors, intermittent difficulty in getting quick appointments has been the most common complaint, said Dr. Duane Davis, medical director of the health plan.

When Supervision Is From Within

For all its emphasis on efficiency, Geisinger does little of the routine oversight that is now so prevalent in the health-insurance industry and so annoying to doctors. Instead, the doctors, with leadership from department heads, are expected to watch themselves for unjustified variations in individual practice and opportunities for improvement.

"We have a high awareness of what our colleagues are doing in the next room," Dr. Blankenship said. "There's lots of intercommunication, lots of informal second opinions. If someone is consistently doing something inappropriately, too much or too little, we'd notice."

Peer review is, however, increasingly backed up with research and suggestions from above. The H.M.O., for example, keeps track of prescribing patterns and sends out newsletters urging physicians to prescribe cheaper drugs or generic versions where they have been shown to be equally effective. One recent flyer warned that a drug company was "actively encouraging pharmacists to call physicians to switch patients" from current diabetes drugs to its new product, priced 40 percent higher even though it offers "no therapeutic advantage."

In another example, officials studied whether patients who were put on an expensive cholesterol-lowering drug were first asked to experiment with dietary change. By sharing the results with other physicians and stressing the recommended course, doctors found that the proportion

of patients trying diet changes had risen. Some will end up needing the drug anyway, but some will avoid indefinite use of a drug that can have dangerous side effects.

As the country seeks to flatten out its health costs, the question is how far even the best-organized providers can trim back without choking off tests and treatments of significant potential benefit.

Dr. Beck said he believes that Geisinger and other similar groups still have large opportunities to wring out expense. Increasingly important, he said, will be reliance on clinical guidelines that reflect research, done locally or nationally, on what sequences of tests and treatments yield the best results for particular conditions.

Still, Dr. Beck said, "At some point there will be tradeoffs between cost and quality." If price controls are too severe, he said, society will have to openly face the issue of rationing.

Modern Healthcare*September 7, 1992***Provider groups finding success with managed care, study says**

Managed care, a key cost-containment and quality-improvement technique included in almost every local or national healthcare reform proposal, is being implemented by provider groups in communities across the country.

That's the finding of the National Committee for Quality Health Care, a Washington-based coalition of providers and suppliers, which has put together a report profiling 19 successful provider-based managed-care programs throughout the United States.

The report, "Reinventing Health Care: The Revolution at Hand," will be released to the public late this week.

The study was prepared by New Directions for Policy, a fiscal policy consulting group based in Washington.

It's meant to be a companion study to last year's report by the NCQHC describing several successful managed-care projects initiated by healthcare buyers, said William Dwyer, director of corporate account development at Abbott Laboratories and chairman of NCQHC's managed-care subcommittee.

Many providers also have developed effective models of community-based managed-care programs, but policymakers and analysts have tended to overlook them because of all the publicity garnered by the corporate efforts, Mr. Dwyer said.

The report shows that decision-makers can learn much from these lesser-known examples of how to construct successful quality-improvement programs and operate them within a coordinated healthcare system, he said.

The provider organizations profiled represent essentially two models for delivering services: those based on group practices, such as Lovelace Medical Center and Health Plan in New Mexico and Geisinger Medical Center and Health Plan in Pennsylvania, and hospital-based network systems, such as Sharp HealthCare in San Diego.

They represent a "small selection" of what provider-initiated programs can accomplish in reforming the healthcare system when they become leaders in promoting community health and wellness, he said.

—Paul J. Kenkel

APPENDIX E

Networking

by Frank Cernie

Sizing up Pennsylvania

Geisinger aims to reshape its delivery system

"If we as a nation are going to get a handle on the escalation of health care costs, and if we are going to be able to provide better health care to more people for less cost, sizing the delivery system is a fundamental part of making that happen."—Stuart Heydt, M.D., president and CEO of Geisinger Foundation, Danville, PA

At Geisinger health system, right-sizing has become a creed, shared by executives and physicians alike, that drives an organization singled out by some health care experts as one of several models for nationwide reform.

Geisinger's structure and operating strategies are built on the assumption that "we are going to have to provide better care to more people for less cost," says Heydt.

Efficiency is the fundamental principle that allows Geisinger to accomplish that mission, from the careful selection of primary care and specialty physicians—most of whom are salaried—to the placement of health care personnel and technology according to patient needs over a wide geographic area.

Integrating system components

Founded in 1915 as the George F. Geisinger Memorial Hospital, a 70-bed facility with a multispecialty salaried group practice, the hospital evolved into a series of separate corporate entities by the late 1980s under the control of the Geisinger Foundation.

System components include the Geisinger Medical Center, a 577-bed tertiary care teaching hospital in Danville with 75 specialties and subspecialties; Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA, a 230-bed secondary care referral center; a 77-bed inpatient chemical de-

pendency treatment center, Waverly, PA; a 145,000-member HMO; and the Geisinger Clinic, a 500-member multi-specialty group practice.

By 1990, Heydt says, it became apparent that Geisinger's management structure and corporate strategies had to change in response to foreseen changes in the health care environment, primarily the increasing emphasis on vertical integration of services and managed care.

Geisinger executives then identified strategies that would be needed to carry the organization into the future:

- Geisinger functions as one organization.
- Clinical programs and clinical process improvements determine the size and direction of the Geisinger system.
- Managed care is Geisinger's primary business strategy.
- Geisinger seeks collaborative opportunities to increase access to cost-effective services.

Although Geisinger still maintains separate corporate entities for legal purposes, there are no independent boards or management structures that identify them as such; Geisinger has corporate and regional managers for the system's east, west and central regions.

The system spans 31 counties in north-central Pennsylvania, a rural region with a population of 2.1 million. Heydt says that Geisinger's approach

to "sizing" the system is to design the network in the most efficient and effective manner.

To achieve that goal, Geisinger has established a network of 45 primary care clinics staffed by salaried physicians employed by the Geisinger Clinic. The physicians offer services to Geisinger Health Plan (GHP) members, as well as to other patients.

GHP also contracts with other rural primary care clinics, 13 community hospitals and approximately 450 private-practice physicians in central and northeastern Pennsylvania.

Heydt says that physicians and management determine how to best distribute resources throughout the system to build a vertically integrated network of primary, secondary and tertiary care that provides the appropriate level of care to communities.

"We know that we have to size the system according to the needs of the populations we serve," Heydt says. "That way you not only provide greater access to high-quality services, but you also avoid duplicating services and adding expensive technology."

PARTICIPANTS:

- Geisinger Medical Center
- Geisinger Wyoming Valley Medical Center
- Geisinger Clinic
- Geisinger Health Plan
- Marworth Chemical Dependency Treatment Center

UTILIZATION (FY 1993)

Admissions: 30,616
Clinical sites: 45
Clinical visits: 1.2 million
HMO members: 144,296

PAYER MIX (FY 1992)

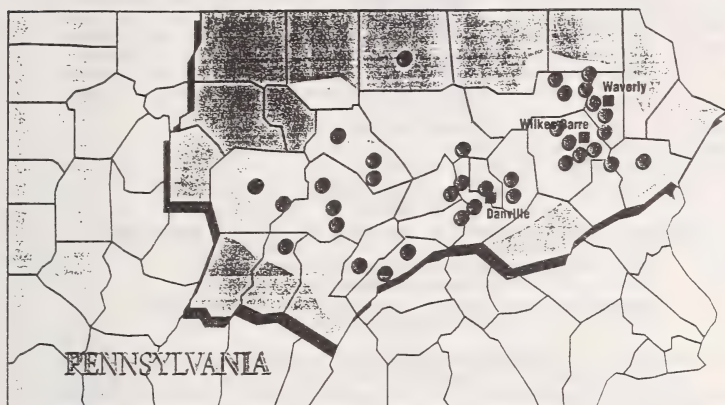
Medicare: 37%
Commercial (includes GHP): 32%
Medicaid: 10%
Blue Cross/Blue Shield: 16%
Self-pay/other: 5%

EMPLOYEES (FY 1992)

Physicians: 499
Physicians in training: 198
Total employees: 7,656

The right physician mix

"Sizing" the system means placing physician specialists and referring primary care physicians in areas where



● Geisinger medical group locations ■ Geisinger inpatient facilities — Geisinger health plan service area — Geisinger service area

they are most needed.

"If you assume in a rural area that people will visit their family physician, how many pediatricians and pediatric subspecialists do you need to have? Where would they be located in order to provide support for family practice physicians?" Heydt asks.

Geisinger plans to find the answer to those questions by analyzing the ratios of primary care physicians to specialists in populations served by other systems (such as Kaiser Foundation Hospitals), and by analyzing its own demographic and epidemiological data, an extremely difficult process, Heydt says.

"We realize we can't simply build a system to suit our needs. We have to make sure that our resources correspond to the actual needs of the populations we serve," he says.

Geisinger has 500 salaried physicians, and 30 percent of the system's clinical practice comes from its HMO, so the alignment of physician incentives is a crucial part of Geisinger's strategy.

Heydt says the system needs to be more creative with physician incentives

in the future, with capitation expected to become the dominant payment method. Nearly 30 percent of Geisinger's gross patient service revenues come from GHP.

"The concept of prospective payment for a defined population on a per-capita, risk-adjusted basis, with physicians managing that financial resource, is something we need to learn to do," Heydt says. "We need to be at risk in terms of utilizing resources to treat a defined population."

Heydt says quality assurance and utilization review activities are made easier by Geisinger's structure: a salaried multispecialty group practice, which allows physicians to police themselves.

The Geisinger Health Plan contributes to this process by centrally collecting and disseminating information about all of Geisinger's quality improvement activities.

"We are also trying to find ways of milking more information from our growing medical claims data base so that we can learn more about the practice of medicine as we conduct it," according to William MacBain, a senior

vice president and administrative director of GHP.

Expansion through collaboration

GHP is licensed to offer coverage in 25 Pennsylvania counties and has contracts with 500 employers. Managed care is the system's stated business strategy, so Geisinger is looking for partners to integrate into its network.

Areas in which Geisinger will seek expansion will depend on the needs of the population, and on where resources need to be located to best serve that population.

Heydt says Geisinger has approached providers in the region to determine how they can share their combined resources to better serve the needs of the populations they jointly serve.

Such discussions have helped identify potential partners, but antitrust concerns have had a chilling effect. "We think such discussions are appropriate, if they don't occur with the intent of violating some of the principles of antitrust, such as price fixing," Heydt says, "but we've had to tiptoe through this process." ■



NAMES

National Association for
Medical Equipment Services

Written Testimony
of the
National Association for Medical Equipment Services
on
"Inner Cities and Rural Issues"
presented to the
House Ways and Means Subcommittee on Health
Hearing
of
Monday, February 7, 1994

The National Association for Medical Equipment Services (NAMES) is grateful to have the opportunity to provide written testimony to the subcommittee on meeting the needs of persons with disabilities and the elderly in "inner cities and rural communities." NAMES represents over 2,000 home medical equipment (HME) suppliers, who provide quality, cost-effective HME and rehabilitation/assistive technology equipment and services to consumers in the home.

NAMES and the HME services industry applaud the Administration for including HME services and custom devices as part of its "standard benefits package" because HME is demonstrably cost-effective and persons with disabilities and the elderly far prefer to recuperate from an illness or injury at home. In addition, NAMES is extremely pleased that the Administration's proposal includes a long-term care component that allows individuals with disabilities and older Americans the opportunity to further utilize HME equipment and services.

However, the following two key issues in the Clinton Administration's plan need further consideration:

1. Competitive Bidding

As the health care reform debate advances, with the goal of maintaining and improving quality health care for millions of Americans, NAMES believes Congress should not consider implementing competitive bidding for the HME services industry as proposed in the Administration's plan. Competitive bidding will reduce the provision of quality HME services for persons with disabilities and older Americans living in both inner cities and rural communities.

Specifically, the Administration's plan seeks to implement competitive bidding for oxygen and oxygen equipment, parenteral and enteral nutrition (PEN) and "such other items and services" as determined by the Secretary of the Department of Health and Human Services. This provision is part of the \$238 billion in Medicare and Medicaid cuts over five years that will help pay for the Administration's proposal.

The provision of HME for persons with disabilities and older Americans requires extensive services. Providers of HME deliver much more than just the equipment; the more critical component of HME is the service rendered, which includes but is not limited to setting up the equipment, explaining how it operates and maintaining it. Experience indicates that competitive bidding systems do not guarantee the maintenance of high levels of quality service. The bottom line is that competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to all Americans.

Competitive Bidding Studies

In 1986, the General Accounting Office (GAO) studied eight Health Care Financing Administration (HCFA)-initiated competitive fixed-price contracts, conducted on an experimental basis for Medicare carriers and intermediaries. After examining seven of the contracts, GAO concluded that HCFA lost money on four of them (Medicare - Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, April 1986). In that same report, GAO made the following observations:

- A major change in the method of contracting used in the Medicare Program is not justified because the competitive fixed-price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program;
- The frequent use of this method of contracting could increase Medicare administrative problems, including the risk of poor contractor performance; and
- There is potential for disrupted service.

HCFA also has studied and recommended the implementation of competitive bidding for many years -- without success. Between 1985 and 1990, Abt Associates of Cambridge, Massachusetts, was under contract with HCFA to evaluate competitive bidding as a method of purchasing home medical equipment. One Abt Report summary stated that:

"Competitive bidding processes per se will not necessarily result in lower Medicare costs (service and administration) for DME or clinical laboratory services in comparison to other available reimbursement methods. The ability of competitive bidding to realize savings for Medicare, while safeguarding quality, depends critically on the design, implementation and subsequent administration of the bidding system adopted. This review of the empirical literature has raised a host of issues for DME and clinical laboratory competitive bidding demonstrations, while providing considerably fewer findings that can be put forward with confidence."

From these studies alone it is clear that competitive bidding on HME should not be an option for the Medicare program. NAMES does not oppose competition in the health care marketplace, provided that the quality of patient care and services are maintained. However, no data has been presented to indicate that inadequate competition exists today in the HME services marketplace. Indeed, the increasing number of new entrants indicates that competition is flourishing.

Complexity of Implementing Competitive Bidding

Competitive bidding for certain HME items has been tried and subsequently abandoned in a number of states, undoubtedly due to implementation problems on that level. Even more enormous complexities would arise in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services. The following consequences are probable:

- Rural communities across America will be most affected as they will not have access to hundreds of medical equipment supply items;
- Successful bidders for oxygen and other major products will not be able to provide reasonable coverage for the delivery of the full spectrum of HME items and services to all of the areas and regions throughout America; and
- Successful bidders will be delivering a significant portion of HME services. Therefore, the smaller companies that provide and service less costly and lower volume items simply will not be able to continue to provide delivery of these items, subsequently forcing them out of business. Severe delivery delays for

equipment and services by large companies that may maintain their presence through the bid will occur because of the high cost of delivering HME beyond any reasonable distance, across urban areas and throughout rural areas. Thus, hospital discharges to the home will be delayed and hospital admissions will increase, while patients are waiting for the required equipment to be cared for at home.

Cost of Competitive Bidding

Under competitive bidding structures that currently exist for oxygen in the Veterans Administration (VA), there are expectations of equipment delivery time that range from 24 hours to 72 hours from the time the order is initiated. This delay is necessary to allow the bidder, who now has the contract, time to service the large geographic area as well as to be as efficient as possible in order to stay in business under the lower competitive bidding rates.

- With delivery delays, there will be an increase of overall health care delivery costs. Patients will experience delays in discharge (which will severely disrupt the current DRG structure under Medicare Part A), while waiting for service.
- Under a competitive bid structure, the service levels will deteriorate significantly. Follow-up visits by health professionals that facilitate ongoing and thorough patient/physician/provider interaction, patient/caregiver education and monitoring of adherence to physician orders will be eliminated or considerably reduced.
- Emergency service (24 hours per day) will be compromised because of the distance that companies typically travel to care for patients under a competitive bidding structure. Routine maintenance checks of equipment servicing will be cut back due to cost constraints, causing concern for patient safety.
- If only one re-admission for acute exacerbation of COPD occurs, which otherwise could have been avoided by providing the high level of in-home service that exists today, the cost of that admission to the federal government will exceed the savings achieved under competitive bidding for that individual patient for several years.

The Service Component

With any competitive bidding system, the first issue to consider must be a determination of what level of service provided by HME suppliers the government is willing to pay. Otherwise, the government should be concerned that the service component -- so integral to assuring patient health and safety -- may diminish or disappear. As an example of how competitive bidding has not worked, HME providers from Minnesota have expressed concern about service-related problems associated with Minnesota Medical Assistance Contracted Providers, those companies that have been awarded Medicaid contracts with the state. Some problems include:

- Inadequate patient education and training on equipment;
- Poor professional follow-up services to determine if the patient is properly using the equipment;
- Irregular equipment checks to determine if the equipment is properly working; and finally,
- Contracts that allow a wait of as long as 24 hours from the time the initial physician's order is received by the supplier until the equipment is delivered and set-up.

Americans with disabilities and older Americans alike will suffer significantly under competitive bidding because access to the custom, highly specialized equipment that they require will diminish. NAMES estimates that the small percentage of HME suppliers who could remain in business under this type of structure would not be able to provide this type of high cost, low margin and highly serviced equipment to all corners of the country.

One HME provider in Minnesota, for instance, services approximately 100 oxygen patients with 90 of them being Medicare beneficiaries. Typically, he provides an average of three after hours (evenings and weekends) calls per week to provide emergency service to patients or new set-ups. If these patients were not serviced adequately and on a timely basis, then costly hospitalization would result. Often, new orders for oxygen in the home are initiated from an urgent care clinic or hospital emergency room, thereby avoiding hospital admission.

Under competitive bidding, a rapid response time by a limited pool of providers will not be possible. The upshot could be an additional and more costly hospital admission.

Other Competitive Bidding Models

Competitive bidding is known to work poorly both for the Defense Department and the VA, where this technique already is used on a large scale, similar to what Medicare would require. VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) due to the poor quality of home care provided by VA competitive bidding contract winners.

Under the Administration's plan, we would have to expect similar, if not greater, problems in access and quality. The VA, once acquiring a signed contract in certain states, has monitored the provider for provisions of services only to find they have no awareness of home oxygen and HME items in the areas of: quality; appropriateness of equipment; various types of equipment; safety features of equipment; and current pricing of equipment.

British Columbia, Canada, has had a competitive bid process for HME services in place since November 1991. There, the government uses a scheme of establishing a "preferred" provider based on the lowest bid and up to 2 "approved" providers based on the next lowest bid in each health unit (7 units in British Columbia). Typically, this system allows for:

- 48 hours to set up new patients, from time of initial order;
- A three-year bid period with the government option to renew every year if the provider is not performing based on confirmed complaints;
- Concentrators, liquid oxygen systems, portable systems and contents to be bid and paid for separately. Contents are based on actual usage;
- Government mandates on patient follow-ups/assessments done every 6 months as a minimum, but can be done more often if so desired;
- Government mandates that require concentrators to be maintained at a minimum of every three months and more often if desired;
- The preferred and approved vendors compete on service and are permitted to obtain clients based on referral, physician or patient preference, even though providers will be paid at different rates based on their bid; and
- An overall decline in service levels because patients have remained in hospitals longer. Service delays and hospital admissions more than likely have increased because of minimal patient/provider/physician interaction.

Based on the accumulated evidence that demonstrates the inadequacies of competitive bidding and because of the adverse impact we predict that such a system would have on persons with disabilities, HME providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment services.

2. Freedom of Choice

Especially important, all Americans should have freedom to choose their health care providers. The Administration's proposal encourages health plans to operate as efficiently and cost-effectively as possible. This objective, while laudable, could allow health plans to contract only with one provider in a given field. Such a practice, however, would limit the choices of available providers from which consumers can select. And, as such, HME suppliers from whom consumers may have received care in the past or whose companies are closer to home could be closed out.

NAMES already is beginning to see situations develop where consumer choice is being severely limited because some HMOs will contract only with one HME supplier. Our concern is that reducing the number of providers in a given field will result in decreased competition, eventually driving up prices, while diminishing quality of care. No single provider can adequately cover as large a geographical and populated area, across many miles and through dense inner cities, as envisioned in the Clinton plan. Suppliers also vigorously oppose the concept of a competitive bidding system for HME items that essentially would lead to diminution of services and quality.

NAMES recommends that the final health care reform legislation should provide incentives for health plans to contract with as many providers as necessary to meet the needs of the community. At the very least, there should not be any disincentives in the system to allowing full provider participation. As well, administrative simplification of forms and the processing of reimbursement claims would help eliminate some of these disincentives.

In the midst of the current health care reform debate, the one solution to rising costs that emerges as an efficient, affordable, and compassionate option is HME services as part of home care. HME suppliers meet the needs of a wide range of individuals who require medical equipment and services in their homes. Suppliers not only provide many of the more "traditional" items of equipment such as those envisioned when the Part B "DME" benefit was first adopted as part of the Medicare law in 1965; now we also provide a vast array of highly specialized and advanced services, such as infusion therapy for the provision of antibiotics and chemotherapy, oxygen and ventilator systems, and advanced rehabilitation equipment. Comprehensive health care reform should establish no impediments to the use of home care and HME services that are currently available or to the enhancement of care in the home and other non-institutional settings.

NAMES and HME suppliers are ready to assist Congress in any way possible as you debate national health care reform, by providing additional information on the HME services industry's concerns described above and how they relate to persons with disabilities and older Americans.

TESTIMONY OF GAIASHKIBOS
PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS

INTRODUCTION

Mr. Chairman and Members of the Committee on Indian Affairs, good afternoon. My name is gaiashkibos. I am President of the National Congress of American Indians and Chairman of the Lac Courte Oreilles Band of Ojibwe Indians of Wisconsin. I would like to thank the Committee for the opportunity to appear before you regarding the most important issue of health care reform for our nation's first citizens.

The National Congress of American Indians (NCAI) is the oldest and largest federation of Indian nations committed to the promotion of tribal governments and the protection of Indian rights. Our membership currently exceeds 162 tribes. Established in 1944 and celebrating presently our 50th Anniversary, the NCAI is devoted to advocating the interests of American Indian Tribes and Alaska Natives. It is in this spirit that I appear before you today.

Mr. Chairman, before I begin with the main body of my remarks, I would like to draw the Committee's attention to a resolution passed recently by our membership regarding health care reform at the organization's annual convention this past December in Reno, Nevada. (See Attachments). I ask respectfully that the resolution, along with my statement, be entered into the record.

It is my understanding that the purpose of today's hearing is to solicit commentary generally on S1757, the American Health Care Security Act, as it is perceived to affect Indian Tribes, and hear

specifically comments on the interface between the President's National Health Care Reform proposal and the Indian Health Service. Accordingly, my testimony begins with a brief overview of some of the principals the NCAI believes are essential in order for meaningful health care reform be achieved for American Indians and Alaska Natives. I further raise what I believe are some of the more serious questions and concerns about the scope of health care services that will be provided in Indian country. Indeed, it is imperative that Indian country be provided all the information that is necessary to weigh carefully, the merits of the President's proposal.

BACKGROUND

It was with anticipation and great hope that I awaited formal introduction of the President's Health Security Act (S.1557) into both houses of Congress some 2 months ago. I certainly am among those who believe that health care in this country, particularly for American Indians and Alaska Natives, is in a state of emergency. At the outset, I am generally encouraged that the President's health care proposals for Indian country are premised in the recognition of treaty commitments and the system of health care that has been developed over the years to fulfill the government's responsibilities in addressing health care needs of Native Americans by maintaining as the principal component of the health care delivery system that would serve Indian country, the Indian Health Service (IHS). There is no doubt that the federal government's responsibility for the provision of health care to this country's first citizens arises out of commitments that the United States made upon entering into treaties with Indian nations. Moreover, Mr. Chairman, this is no doubt that the Native people of this country have paid dearly for the benefits they receive. We've ceded millions of acres of land, --in many instances our home lands -- in exchange for a promise of health care. For decades, we have suffered in a system of rationed health care, a system which

has been seriously and severely underfunded from the outset. There must now be proper assurances that health care reform for the Native people of the United States is meaningful and tangible, and not simply yet another unfulfilled promise by the Federal Government.

QUESTIONS AND CONCERNS REGARDING HEALTH CARE REFORM FOR
NATIVE AMERICANS

There is no question that the Health Care Security Act would have a significant effect upon the relationship between the Indian Health Service and the population it serves. And, there is no question that the National Congress of American Indians supports the general principles of the Health Care Security Act. We believe in the principles of universal health coverage for all Americans and believe in action to control the soaring costs of health care. However, in order to fully evaluate the merits of the President's Health Care Reform proposal, and to provide meaningful input in order to achieve more efficient and effective health care systems for Indian country, some fundamental questions must be answered and some basic assurances provided.

1. Funding

It is essential that sufficient funding to fully support services for Indians be made available, consistent with the government's trust obligations to American Indians and Alaska Natives. The NCAI is very concerned presently that funding for Indian health programs within the Act is wholly inadequate to support the costs of delivery of the guaranteed benefit package to American Indians and Alaska Natives. In short, Mr. Chairman, we are concerned that the President's plan continues a long history of the severe underfunding of Indian programs. The many worthwhile objectives contained in the Act simply cannot be realized without proper financing. At best Mr. Chairman, the current level of funding for the health care programs designed to serve

Indian people who reside in reservation communities permits the IHS and the tribally operated programs to address less than 50% of the overall health care needs of the Indian patient population. Under the IHS operated programs, this includes some 42 hospitals and 65 health centers. Under the Tribally operated programs, which represent a growing component of the Indian delivery system, tribes operate approximately 8 hospitals and 93 health centers. And while the Congressionally mandated mission of the IHS is to elevate severely the health status of Indians to the highest possible level, limited federal funding has forced IHS to severely ration its services. I now understand that the President's targeted request for Fiscal Year 1995 for IHS will further reduce the capacity of the Indian health care system to address the needs of our communities. All the while, there remains a soaring unmet need for safe water and sanitation systems. According to its own estimates, only 15 of the nearly 500 IHS facilities currently has the potential to provide the full range of health care services that are part of the comprehensive benefits package guaranteed to all other Americans under the Health Care Security Act sufficient funding is vital.

We must have some concrete answers to questions about the costs to provide all of the benefits listed in the Comprehensive Benefits Package (CBP). Further, we must know more precisely what it will cost to maintain the same level of supplemental benefits which the IHS currently provides. It would be helpful if Tribes knew what amount the Administration expects Tribes to spend on renovation and expansion through the revolving loan fund. We need to know what will happen to the Medicare and Medicaid payments which Tribes currently collect, under the Act. It is imperative that the Administration and Congress commit to seeking a sufficient level of funding necessary to provide the same comprehensive benefits other Americans are guaranteed under the Act, at a minimum the same level of supplemental benefits that currently exists and to

achieve the renovation and expansion of facilities called for under the Act.

2. The Government-to-Government Relationship

In order to be consistent with the principles of Self-Governance, the NCAI believes the Administration should have consulted with Tribes in drafting the Indian and IHS sections of the bill. We hope that Congress will listen with a carefully to Tribes throughout the debate on national health care legislation and its impact on Indian people.

Similarly, we are concerned that the Act has not properly taken into account the government-to-government relationship between Indian tribes and the Federal Government. While the Act provides a number of incentives to states which opt to undergo reform prior to the January 1, 1998 deadline, no such incentives are extended to the Tribes of the IHS. We hope the Administration will agree to provide the same incentives to tribes that it currently is offering to states. We also encourage the Administration to take the necessary steps to see that tribes and states undergo reform at approximately the same time. It troubles me deeply that Indians and Alaska Natives will have to wait an additional year for health care reform under the current provision of the Act.

An additional concern under the government-to-government relationship occurs with respect to service to non-Indians. I know many tribal leaders share this concern. Presently tribes have authority to prevent the IHS from immediately extending services to non-Indians under the Indian Health Care Improvement Act. My understanding is that the President's bill will undermine that authority. The NCAI encourages Congress and the Administration to restore the requirement of tribal consent prior to extending IHS and tribal services to non-Indians.

3. Additional Issues of Concern

The Act authorizes regional health care alliances to essentially operate as large purchasing agents for options of health care plans from which alliance members may select the option which most suits their needs. However, the Act does not resolve the issue of whether the overall IHS service system could function as an alliance, purchasing health care plans for its service population. A principle feature of the health alliances is that they enable the pooling of a sufficiently number of a large number of health care consumers to afford an economy of scale in the purchase of health plans. We are concerned that while the proposal for Indian country may well offer more flexibility for local tribal government decision making, it may result in the loss of economy of scale of purchasing power if the IHS were otherwise deemed to have the state us regional health alliance.

Similarly we are concerned about the retention of the "payer of last resort" policy. I understand IHS will continue "the payer of last resort" in the new era of health care reform. We believe that this policy must be eliminated and that to clarify the role of IHS as the primary provider to Indian people, direct federal reimbursement be provided to Indian Health programs for services provided to patients eligible for third party reimbursements.

The President's plan lacks a strong health promotion and disease prevention component. We believe these programs form the corner stone of any effective health care system and are a vital part of addressing the health care needs of Native populations. We hope that Congress takes the necessary steps that health plans offer health promotion and disease prevention programs as part of the guaranteed benefits packages and that allocations and appropriations for Indian health programs include the cost of these preventive services.

I am pleased that President Clinton's health care plan includes long-term care health care services. However it is unclear just where Indian programs will fit into this system. Under the current system, states fund many long-term care services for low-income Indians through the Medicaid program. It is unclear that such services will continue under the Act. We believe a mechanism should be clearly identified within the President's plan for funding the portions of the various long-term care programs for Indians which would otherwise be paid as part of other state matching funds. We are further concerned that the IHS has no comprehensive long-term care program for older and disabled patients. We hope the Administration remains committed to a strategy for improving health care for the Native American elderly and disabled.

An issue to which I am personally committed as a tribal leader is HIV/AIDS prevention and education. We are faced with an alarming increase of HIV positive Native Americans and patients who have developed AIDS. Unfortunately, funding for AIDS programs through IHS has been sharply reduced. Essential treatment drugs have been eliminated from the IHS pharmaceutical formulary. It is unclear under the President's plan whether such funding would be restored. I believe that a meaningful health care plan would provide, at a minimum, essential treatment drugs.

CONCLUSION

Mr. Chairman, I would like to again thank the Committee for this opportunity to participate in dialogue with the Administration regarding the impact national health care will have on Indian people and the Indian Health Service system. We certainly have a significant amount of work before us. We remain hopeful that the President's health care reform bill will provide an opportunity to address serious problems and improve health care for Native Americans. On behalf of the National Congress of American Indians, we look forward to working with the Administration and Congress to provide meaningful, effective and efficient health care services to this country's first citizens.

**TESTIMONY OF ROBERT E. BARROW
MASTER OF THE NATIONAL GRANGE
OF THE ORDER OF PATRONS OF HUSBANDRY**

I am Robert E. Barrow. I am the Master (President) of the National Grange of the Order of Patrons of Husbandry, which is this nation's oldest, general farm and rural public interest organization. It is a pleasure to speak to you today about the Grange's views on health care reform, especially as it affects the farming and rural areas of our nation.

The impact of health care reform on rural America has received too little attention to date in the public debate on this issue.

After surveying our approximately 300,000 members across the nation on this issue, we have found there is a broad agreement among farmers and rural citizens on many of the basic goals of national health care reform. Grange members support universal access to health care for every American regardless of age, race, income, prior health condition, or where they live. We support efforts to streamline the administrative costs and to contain health care's skyrocketing costs. Grange members support maintaining the freedom to choose one's own doctor.

However, our members are concerned that the unique problems that are facing health care in rural areas are not magically solved simply because we can and should find substantial areas of common ground with our urban and suburban countrymen. Our debate on national health care reform must focus substantial attention on critical rural health care issues that affect nearly one out of every four Americans.

This immense population, distributed across the huge geographic expanse of our nation, means that the United States has a vast rural health care system that no other industrial nation tries to maintain. This fact is important because many modern medical technologies seem to achieve their highest efficiencies as greater economies of scale are found. Unfortunately, these economies of scale are concentrated more and more in heavily populated urban areas.

As a result, rural areas are increasingly facing reduced access to health care facilities. Rural hospitals are smaller than urban hospitals and find it difficult to use modern economies of scale. Rural health care providers have also been subjected to overt discrimination by the federal government's Medicaid and Medicare programs, which have set lower reimbursement schedules for small rural hospitals than for larger urban hospitals.

The difficulties and costs of maintaining quality health care in rural areas can be demonstrated by the experiences of the state of Pennsylvania. In 1989, the Center for Rural Pennsylvania published a report entitled "Health Care Outlook and Opportunities". In that report, the Center found that nearly one-half of the rural counties in Pennsylvania either rely exclusively on small hospitals or do not have a hospital.

The problems concerning access to adequate rural health care services are not limited to Pennsylvania. The Congressional Office of Technology Assessment has found that rural areas cannot recruit and retain qualified health care personnel. One hundred and eleven rural counties in the United States do not have resident physicians. Over one-half million rural residents live in counties that do not have a physician who is trained in obstetric care. Forty-nine million rural citizens live in counties that do not have a psychiatrist.

Access to health care facilities is not the only critical problem facing rural residents. America is an aging society. Persons who are 85 years of age or older are the fastest growing segment of our population. As we age, we tend to require more health care in order to maintain our quality of life. For exam-

ple, the average 35-year old uses about \$1,000 of health care per year. The average person over the age of 85 uses \$6,000 or more a year in health related services.

This problem of an aging population is especially acute in rural areas where the average age is 39 years old as compared to a national average age of about 32 years old. Moreover, the average age of a farm operator in the United States is 53 years old. The critical problems involved with dealing with the increasingly expensive needs of an aging population are already having a tremendous impact on the health care system in our rural and farming areas.

Other issues are also critically important to the rural health care debate. Our nation's public and private insurance systems have systematically discriminated against rural health care providers by providing reduced reimbursement for the same procedures or services that are provided in rural areas as opposed to urban areas. The federal government's policy of not allowing 100% deduction of health insurance costs for self-employed individuals has also been a burden on rural areas because rural and farming communities have disproportionate numbers of self-employed people.

While the National Grange applauds the efforts of the Administration and Congress to advance the goals of health care reform, we can't help but have nagging concerns about the details of the President's plan as presently formulated. Our chief worry is that "Health Care That is Always There" will turn into "Health Care That is Always (Over) There" for rural Americans. We fear the continued consolidation of health care facilities outside of areas that are easily accessible to rural citizens. In our view, forcing farmers and other rural citizens to travel greater distances to receive primary to secondary health care is not health care reform. It is merely cost shifting and risk shifting in another form.

Guarding against discriminatory forms of cost shifting and risk shifting will require all of us who are concerned about health care in rural America to remain actively involved as the debate on health care unfolds over the next few months or years. There are literally hundreds of issues where rural citizens have a distinct interest in how the details of health care reform are finally worked out. I would like to offer a few of the key issues that the Grange believes will tell us whether or not health care reform will be beneficial or detrimental to rural areas:

1. Global budgeting - If the President's proposals for global budgeting rely primarily on historical spending patterns, then health care reform will only lock-in the discrimination that has historically occurred in rural areas.
2. Relaxing the standards of health, safety, or consumer protection. Several proposals to increase the availability of health care in rural areas involve relaxing certain government standards that are related to protecting the patient's safety or consumer protection. Related proposals call for expanding the use of non physician-administered primary health care in rural areas. We are not opposed to a discussion about these proposals, per se, as part of the national health care debate. However, we are concerned that the merits of proposals like these should be debated for their adoption by all Americans - not just those who live in rural areas. Rural Americans and farmers are not second class citizens who must waive their rights to safety or consumer protection in order to receive adequate health care. If it is cost effective for registered nurses and physicians' assistants to deliver primary health care

in rural areas, we assume those same efficiencies will be found in urban and suburban areas as well.

3. Health Care Alliances - The President's proposal envisions large purchasing cooperatives of one million members or more to contract with health care providers to provide medical services to the Alliance's members. In all but a handful of states, it seems unlikely that most health care alliances will be structured so as to include a majority of rural residents. More likely, health care alliances will be structured around urban and suburban population centers that have significant numbers of rural citizens lumped into the metropolitan-based alliances for convenience sake.

This situation may or may not be beneficial for farmers and rural residents. However, as I have pointed out, rural areas have unique health care needs that may not be adequately addressed in health alliances that are 60%, 70%, 80%, or more urban and suburban based. A key test of the President's reform proposal will be adoption of a program that allows a wider range of options in the formation of health care purchasing cooperatives that recognize, as Revolutionary War hero Ethan Allen once said, "The Gods of the Hills are not the Gods of the Valleys". Rural areas will need to be allowed to withdraw from metropolitan-based health care alliances and form their own purchasing cooperatives if rural areas are going to be able to determine their own health care destiny.

The Grange's interest in rural health care dates back for decades. Many of the State Granges already act as health care alliances for our members by contracting with HMOs and insurance companies to provide quality health care services to their members. State Granges operate half-a-dozen long-term health care facilities for Grange members across the nation. Dozens of local Granges across the nation sponsor or actively support Emergency Medical Services in their communities. Health care is a critical issue for our State Granges and local Grange chapters.

At the National level, the Grange is sponsoring a multi year political education and action program called "Health Care in America". At our request, nearly 1,700 local Granges wrote to First Lady Hillary Rodham Clinton urging her to consider the unique problems of rural America as the Administration drafted its health care proposals. We have published and distributed nearly 5,000 copies of an information brochure entitled "Health Care in America: Issues, Questions, and Facts". I proclaimed this past September "Health Care in America Month" and asked our local and State Grange chapters to hold meetings on health care reform and to sponsor free blood pressure screenings to help make people aware of their personal responsibilities of maintaining good health as an integral part of any national health care reform.

The National Grange is committed to working with the Clinton Administration, Members of Congress, and our allies and friends in rural areas that are represented by colleagues at this table to secure affordable health care for all Americans. We believe our job is to make sure that the unique problems and challenges of providing adequate health care in rural America is incorporated into any final national health care reform plan.

Thank you.

**H.R. 1200, AMERICAN HEALTH SECURITY ACT
OF 1993; H.R. 2610, MEDIPLAN ACT OF 1993;
AND OTHER SINGLE-PAYER OPTIONS**

WEDNESDAY, FEBRUARY 9, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, JANUARY 27, 1994

PRESS RELEASE #26
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON

HEALTH CARE REFORM:

H.R. 1200, THE AMERICAN HEALTH SECURITY ACT OF 1993;
H.R. 2610, THE MEDIPLAN ACT OF 1993; AND OTHER SINGLE-PAYER OPTIONS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on H.R. 1200, the American Health Security Act of 1993; H.R. 2610, the MediPlan Act of 1993; and other single-payer health care reform options. The hearing will be held on Wednesday, February 9, 1994, beginning at 10:00 a.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark stated: "A single-payer health care system, such as the Canadian system, is the simplest and most straightforward alternative for solving the problems facing our health care system today. The Congressional Budget Office has found that such a system has the highest potential for controlling health care costs. For these reasons a hearing to explore the feasibility of a single-payer system is a necessary part of our examination of options for health reform."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

H.R. 1200, the American Health Security Act of 1993 was introduced by Mr. McDermott, Mr. Stark, Mr. Rangel, Mr. Lewis (Ga.), Mr. Gibbons, Mr. Coyne, Mr. Ford (Tenn.), et al.

H.R. 1200 would establish a single-payer model of health care, providing coverage for all Americans. The provision of health care services would remain in the private sector and individuals would not obtain their insurance through their employers. Patients could select their own physicians and there would be no deductible, coinsurance, or copayment required. The benefit package would include all preventive, hospital and outpatient medical services. In addition, the plan would cover long term care, mental health services, prescription drugs, and substance abuse treatment. The plan would be administered by the States, and providers would bill the State for covered services.

The plan would be Federally financed. The Federal Government also would define the standard benefit package and collect the premiums. Financing would be through payroll deductions, a tax on tobacco products, and an excise tax on handguns and ammunitions. Savings from the elimination of health insurance products would be used to subsidize care for low-income persons.

H.R. 2610, introduced by Mr. Stark, Mr. Coyne, et al, would extend benefits under the Medicare program to all Americans and is similar to a proposal introduced by Mr. Stark in the 102nd Congress, H.R. 650, the MediPlan Act of 1991. The bill would assure health insurance protection modeled on the Medicare program.

It incorporates the national health budget and reimbursement systems currently included in H.R. 200. The budget would be used to establish provider payment rates, and to assure that costs are contained within limits. Total expenditures would be gradually reduced to the rate of increase in the gross domestic product.

The bill would provide Federal regulation of MediPlan supplemental insurance. Any additional costs would be financed through a new 10-percent tax on gross payments received for MediPlan benefits by health care providers. In addition, every individual (except lower-income Americans) would pay the MediPlan health benefits premium (about \$1,500/person; \$3,000 per working couple) through the income tax system, and employers would pay 80 percent of the MediPlan health benefits premium.

Benefits under Medicare would be enhanced by the bill. Basic benefits would include Medicare benefits except that a single deductible of \$350 per individual (\$500 per family) and an out-of-pocket limit per person of \$2,500 (\$3,000 per family) would be added. Prescription drugs would be added with a separate deductible, and prevention benefits would be covered without cost sharing.

The bill would encourage States to continue their experiments with their own reforms. States, subject to minimum Federal guidelines, could opt out of the national program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Wednesday, February 23, 1994, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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Chairman STARK. The committee will come to order.

The chairman would like to announce that the committee is going to continue its hearings on health reform today and deal with the single-payer option. The chair has a 2 page opening statement which lauds the merits of the single-payer system, and I would ask unanimous consent to dispense with the reading of this laudatory opening statement and have it appear in the record alongside of the laudatory statement that I am sure my distinguished colleague from California, the ranking member, would like to make in his opening statement.

[The statement referred to follows:]

**OPENING STATEMENT
THE HONORABLE PETE STARK
COMMITTEE ON WAYS AND MEANS**

February 9, 1994

Good morning.

Today, the Subcommittee on Health continues its series of hearings on health care reform proposals with testimony regarding the so-called "single payer" options for reform.

There are two primary approaches to a single payer approach to health care reform. The first is HR 1200, the American Health Security Act of 1993, introduced by Representative McDermott and others. I introduced the second alternative, HR 2610, the MediPlan Health Care Act of 1993.

Single payer proposals meet every one of the President's objectives for health care reform. They would guarantee universal coverage and limit the growth in total health spending, with scoreable savings. In fact, the Congressional Budget Office estimated conservatively that by the year 2002, reforms along the lines of H.R. 1200 would reduce national health expenditures by 70 billion dollars, with savings escalating in subsequent years.

Both of these proposals would preserve patients' freedom of choice. Unlike many of the competing health reform proposals, the single-payer approach allows every American the financial freedom to choose his or her own doctor, specialist, and hospital.

Probably the greatest virtue unique to the single-payer reforms are their simplicity. Everyone is covered under the same system. Providers have only one set of rules by which to play. And, in comparison to every alternative health reform proposal, a single-payer system wastes the least amount of scarce resources on excessive administrative costs.

The idea of a single payer system is not radical, as some would like us to believe. In essence, Medicare is a single-payer system for the elderly -- and a very successful and popular system at that.

Since 1965, Medicare has insured virtually all senior citizens under a single public plan. Medicare now provides universal and guaranteed coverage to some 35 million Americans. Individuals entitled to Medicare benefits have complete freedom to choose their own hospitals and doctors.

Unlike any private health insurer, Medicare's administrative costs are between 3 to 4 percent of total expenditures. Given this record of efficiency, I am hard pressed to justify alternative health reform plans that require higher payments to cover the overhead of private health insurers, which ranges up to 40 percent.

Medicare has a proven record of effective cost containment. The Medicare program has pioneered innovative payment methodologies. In fact, many private insurers have started to follow the lead of Medicare in the use of the physician resource-based relative value scale (RB RVS) and the hospital prospective payment system based on diagnosis related groups (DRGs).

Medicare is a popular program. It works. It has been tested by some of our most critical and outspoken constituents. And they like it. It is an all-American health insurance system, which takes good care of our parents and grandparents.

Of course, Medicare is not perfect, and could be improved, as it has been over the course of the past thirty years. Nonetheless, I dare say we would be very fortunate indeed if, at the end of this year, we produce a health reform plan as popular and successful as Medicare.

A single-payer plan, such as either H.R. 1200 or H.R. 2610, would provide all residents of this country health insurance coverage that is guaranteed and portable. It would provide seamless coverage -- without regard to income, employment or medical problems.

I urge my colleagues to take a careful look at the merits of these two bills as we work to pass health care reform legislation during the next few months.

Mr. THOMAS. Mr. Chairman, I do not have a written statement lauding the single-payer system that I would put in the record, but I would say that I am pleased that CBO has finally given us some numbers on the President's, so that we can begin to compare other plans.

We have taken testimony from a lot of people in the health care industry, and I look forward to begin to hearing testimony from our colleagues who have spent a lot of time looking at this questions and clearly have different ways of delivering what all of us are interested in, and that is health care to all Americans.

Thank you, Mr. Chairman.

Chairman STARK. We have an opening panel consisting of three distinguished members. We are awaiting the arrival of Hon. John Conyers of Michigan, who is on his way.

We are joined by a distinguished member of our subcommittee, Mr. McDermott, and my neighbor and colleague from California, Hon. George Miller.

In the interest of time, Jim, why do we not have you start off?

STATEMENT OF HON. JIM MCDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I am here today really as the coauthor of H.R. 1200, the American Health Security Act, and I want to thank the subcommittee for the opportunity to testify about this issue.

This subcommittee and the Congress are beginning a historic debate on national health care reform. It is long overdue, and I know that many members on this committee have been actively working on this issue for many years.

President Clinton deserves much credit for placing health care reform first on his agenda for the Nation. It is now time for the Congress to respond to the challenge, and I think we all welcome that challenge.

We are all aware of the need for the reform of the Nation's current system of providing and paying for health care. I am not going to waste your time convincing you of the existence of health care crisis. The American people know the indisputable reality of this crisis. And as far as I am concerned, anyone who tries to convince them otherwise can defend that position at the polls.

The time has come to start making decisions. So far, the debate has focused really on competing slogans. But we all know that slogans are not going to be enough on this issue, because every citizen will be personally affected by this vote, and if we mislead them with slogans, every voter will know it in a very short time.

We are at a fork in the road. Yogi Berra said: "When you come to a fork in the road, take it." We can now consolidate the control of the insurance companies over our health care delivery system and spend all our resources policing how they do the job, or we can give that control to the American people.

H.R. 1200 will give you the chance to vote for something that will cost your constituents less and give them more than they have ever had, and you will be able to explain to them exactly how it will work. I believe that is a vote that can you defend.

Every other option, including the status quo, will cost them much more and give them much less. They may not understand that today, but they will figure it out in a very short time, and they will hold those of us who failed to seize the opportunity for the best accountable.

So let us talk reality and substance. Let us really talk bottom lines.

I am here today to discuss a proposal which at least 92 other members, including my colleague, Mr. Miller, feel is the most cost-effective approach to preserving the best aspects of our current system, while taking bold and necessary new steps to correct the inequities and shortcomings of our current system of health care financing.

In short, H.R. 1200 offers the best approach to health care reform because it is simple; it is universal; it is proven; and it is efficient.

H.R. 1200 in a single-payer model of health care financing which guarantees—and I underline “guarantees”—universal coverage while preserving the best aspects of the current private delivery system. This is in sharp contrast to other proposals currently before the Congress.

President Clinton’s plan aspires to universal coverage, but it will achieve this only through a tremendous disruption of the present system which has never been tested before. Other proposals before the Congress do not even pretend to achieve universal coverage.

Most significantly, H.R. 1200 accomplishes the goals the universal coverage, the preservation of the current private physician/patient relationship, and offers the most comprehensive benefit package, while accruing the largest savings compared to any other proposal.

According to the CBO, who was here yesterday, the single-payer approach will save up to \$175 billion a year from the Nation’s health care bill by the year 2003. That compares to \$110 billion in savings in the President’s proposal. That is \$65 billion a year more savings.

Moreover, the single payer achieves these additional savings while providing the most generous benefit package, including full long-term care and while providing a much more generous growth rate than the President’s plan permits. Our growth rate is politically attainable, which makes our savings real. In addition, up to \$100 billion will be saved in administrative savings alone.

CBO yesterday did not report any administrative savings in the President’s bill. And as you know, the CBO scoring of the Cooper bill last year demonstrated that Mr. Cooper’s proposal would add \$214 billion in health care spending, while leaving two-thirds of the uninsured population still uninsured.

Now I am proud to be here as a cosponsor of the only proposal for health care reform that is fully financed and that guarantees universal coverage, which is a requirement demanded by 78 percent of the American people in polls. There is no smoke, no mirrors, no phony numbers, and unlike the Cooper proposal, there is no hidden income tax penalties for most middle class Americans in addition to their health insurance and out-of-pocket costs, and there is no herding of Americans into HMOs.

Indeed, I commend the cosponsors of the Cooper bill for their political courage in supporting effective income tax increases and business profit tax without offering to find benefits or coverage in return. It really intrigues me how 26 Republicans are willing to support an income tax increase, and I am going to watch with interest how they defend at home this combination of taxes and no guaranteed insurance.

Under H.R. 1200, every American will know exactly how much their health insurance is going to cost them in the foreseeable future, and 75 percent of Americans will pay less in 1999 than they are paying today for their health insurance.

Seventy-five percent will pay less for a benefit package that is the most comprehensive, including home, community-based, and nursing home long-term care, prescription drugs, comprehensive mental health and substance abuse benefits, as well as a full array of preventive and acute care services.

Seventy-five percent will pay less for a plan that will give them unrestricted free choice of provider, not just free-choice of plans.

Seventy-five percent will pay less for a plan which eliminates interference in the doctor/patient relationship by prohibiting precertification of medical decisions by some clerk on a 1-800 number.

Seventy-five percent will pay less for a plan that eliminates for consumers the need to file the reams of paper with insurers and will also reduce the administrative burden on providers.

H.R. 1200 numbers are the cleanest numbers in town. The bill was scored by CBO, and the numbers were sent to Joint Tax to raise the required revenue, period. We yield a \$9 billion budget surplus by the third year and universal coverage in the first year. Our payroll deductions for a public health insurance premium for most small business and for individuals are smaller than the President's plan and definitely less than most businesses and individuals are paying for insurance today.

No one else can tell the American people what their proposal will cost Americans individually for on major reason. No one else can tell the American people what their private insurance premiums are going to cost. No other proposal can verify whether or not these premiums are going to be affordable.

So let us get one thing straight. Universal coverage is affordable. The reason our numbers are the best numbers in town and always will be is because the administrative savings by getting rid of insurance company middlemen more than pay for the universal coverage.

Make no mistake about that. The tortured, cumbersome and, in my opinion, futile attempt to keep insurance companies in the mix is consuming our resources for universal coverage.

Now ask yourself a question. Are insurance companies worth it? Does anybody have a constituency who loves their health insurance company?

Consumers Union found that our bill is the best for all segments of the population and especially for children and senior citizens.

The American Medical Women's Association endorsed our bill as the best for women.

The American Public Health Association endorsed our bill as the best reform for our public health infrastructure.

The American people are not looking for another patch on the health care system. They are looking for a health care system that is simple to understand with clear guarantees on coverage and affordability.

H.R. 1200 is the only proposal that does that. And when you take it home to your constituents, you will be able to explain it, and they will know that they have really gotten something.

Thank you.

Chairman STARK. Thank you.

Welcome to Hon. John Conyers. Would you like to enlighten us in any manner you are comfortable?

STATEMENT OF HON. JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CONYERS. Mr. Chairman, I am delighted to appear here with Dr. McDermott and Chairman Miller. We are making a pretty good team these days, going from committee to committee, pleading our case for the most popular health care reform bill that has been introduced so far in the Congress.

I am glad to see my former colleague on Government Operations, Jerry Kleczka, here, where he abandoned his committee of original first love to join you here.

I just want to fill in a few spots between Dr. McDermott and Chairman Miller on how this bill came into being, and I think it is kind of important that we realize that this was not a philosophically drive bill. It was not ideological.

Years ago, a number of people began looking at the notion of how this system can be made better. Our committee, Government Operations, went to Canada, not only to Ontario but into other parts of the provinces, looking at a system and brought back a plan in which we took some of the Canadian system's ideas. We did not mimic this. Is not a foreign operation. This is an American plan taking the best in our system, and we do have some things in the health care system of which we can be eminently proud and put it into a system that we have to move to.

You know, I am proud of the President for daring to raise this issue in his context when he was asked by a then incumbent: What health care problem?

But I am now beginning to give him more sympathy than I had before, because now I am beginning—I think he is beginning to see how entrenched and formidable the vested interests are in this subject matter.

There are some people who could care less about what would be best for the American people. Their interests are too long and deep and wide, and they are just not going to go about it. And I refer to the rebuff that he received from the business organization only recently in which he has tried to meet them halfway, as it were, and they are attacking him as if he is the sponsor of H.R. 1200, and I wish he was.

Some of our issues are in the Clinton bill, some of our goals. But let me just go through a few of them, and I will yield this great honor.

Universal coverage, here are the things that attracted me to it. I did not come with a plan. I started working on one. Marty Russo started working on one with all of us. It went through infinite changes. Paul Wellstone came into it. You contributed, yourself, Mr. Chairman. George Miller has been in this thing for years.

But let us talk about what it is we are looking at—universal coverage, comprehensive benefits, strong cost-containment, one tier of care—a big star, free choice of provider—fair financing, targeted assistance to the medically underserved, and a strong consumer role.

Now in H.R. 1200—and we have 93 cosponsors—this is what brought us to the plan. It was not a Democratic plan; it was not a—it was a people's plan. And on each one of the points that I have just enumerated, without going into the description, which is my statement, there is no question about which plan brings forward the most. And when CBO and GAO, both impartial and sometimes even critical to the work that is brought to their desks, they scored H.R. 1200 far higher than all the rest, as has been indicated, \$90 billion under GAO and \$50 billion under CBO.

It is there. The problem now is whether or not we have the courage to take on our friendly insurance companies and say: Look, fellows, most of the American people, by polls, want to have a regulation. They want health care regulated if it will keep the costs down. And that is what we have done. Not government-run, not socialized medicine—underlined, not socialized medicine—not England.

And so what we have done is to have put all of these principles together in a sensible way.

The Congressional Black Caucus, I am very proud to say here, has overwhelmingly supported the bill, and we think that as this understanding settles down, I think that the support around the principles of our bill are going to grow.

Now I close on one point, and that is on nomenclature. Is it a premium, or is it a tax? Please tell me. This is a burning question. Is it out-of-pocket? Is it deductible; is it excludable? Wonderful discussion, ladies and gentlemen. But the point is, and the American people have said it to us already, is that no matter what it is described as, it is more money than we can continue to pay every year.

They are saying: Whether it is a premium or a tax, Mr. President, really does not matter. The question is: How much is it every year? And every year under every analysis—independent, governmental, and private—we have come upon what so far is the best plan for serious health care reform that we can bring to this committee at this time.

Thank you very much for your consideration.

[The prepared statement follows:]

STATEMENT OF REPRESENTATIVE JOHN CONYERS, JR.
ON H.R. 1200, THE AMERICAN HEALTH SECURITY ACT,
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
FEBRUARY 9, 1994

Thank you, Chairman Stark, for holding this hearing on H.R. 1200, the American Health Security Act, and for inviting me to testify. It is clear, Mr. Chairman, that the current health care system needs major surgery, not just a bandaid here or there as some people advocate.

I know your Subcommittee has been incredibly busy lately, holding hearings every day. Bob Reischauer of CBO testified before you yesterday to report on the scoring of the Clinton plan. Based on the news accounts, the CBO report predictably resulted in the usual charge and counter charge that only serves to confuse the American people.

I believe the American people want straight talk about health care reform. H.R. 1200 provides this because it is built on the most simple and solid foundation of any reform plan.

- **Universal coverage:** everyone gets it by 1997.
- **Comprehensive benefits:** the best, including comprehensive long-term care, mental health and substance abuse, and prescription drug benefits. With no co-pays or deductibles for most services, unlike other plans.
- **Strong cost containment:** CBO says we save the most, even as we provide the most generous benefits. We save at least \$75 billion more than the President in 2004, with much more generous benefits and little or no cost sharing.
- **One tier of care:** without question. You don't have to pay extra for the privilege of seeing the provider of your choice.
- **Free choice of provider:** No one's forced into a managed care plan under H.R. 1200.
- **Fair financing:** for both individuals and businesses. 75 percent of Americans will pay less. And the plan is fully paid for.
- **Targeted assistance to the medically underserved:** We double funding for health clinics and to place primary care providers in medically underserved communities.
- **Strong consumer role:** at all levels of the program. Decisions aren't left to huge insurance companies.

For these reasons, over 80 percent of the Congressional Black Caucus supports H.R. 1200. And that's why I urge this subcommittee to do the same.

I feel bad for the President right now. He's been trying to do the right thing. I don't believe his health reform proposal is the best way to go. But we all have to give him enormous credit for drafting a serious proposal that provides universal coverage and now, according to CBO, would significantly contain costs in the long run.

I believe the strong criticism leveled at the President's plan shows that he made a major political miscalculation early on.

You can't really solve the health care crisis by appeasing the business community, the insurance companies, the drug companies, and even a lot of the health providers. Their financial stake is too high to expect that they would give up the enormous benefits they derive from the current system. What a surprise that many businesses oppose the Clinton plan. How many years did business fight family and medical leave -- 5 to 10 years? And that program was unpaid and didn't cost them a cent.

The President's program is taking hits all over the place. It's been accused of being heavy on government regulation and big bureaucracy, it would limit patient choice of provider, and it's a new tax on employers. These criticisms are all too predictable from the monied interests that roam the halls of Congress.

The President would have been much better off with a simple and straight-forward approach to health care reform. One that the American people can understand. That's why I coauthored, along with my colleagues Rep. McDermott and Sen. Wellstone, H.R. 1200/S. 491, the American Health Security Act. It's a plan that can stand up to the pushing of hot buttons and phony labeling from the health insurance industry and from our colleagues on the other side of the aisle. For example:

Government Regulation. Let's consider the charge that the plan is heavy on government regulation. Business won't support regulation even if it's in their interests -- such as to effectively control health costs -- because they fear being regulated in other areas. Health providers -- well, we know why they don't like regulation.

But the public sure likes government regulation in health care. A Newsweek poll from this past Sunday found that by 57 to 36 percent Americans support government regulating the cost of care and drugs. Every other major industrialized country controls health costs through regulation -- by negotiating fair prices with providers. It's tested and proven.

That's why CBO said that H.R. 1200 would cover everyone by 1997 and save up to \$175 billion a year by the year 2003. CBO said the Cooper bill would leave 25 million uninsured and raise national health spending by over \$200 billion over five years. CBO felt Mr. Cooper's cost containment strategy was as firm as Jell-O nailed to the wall.

The answer isn't to back away from regulation. It's to use the bully pulpit of the Oval Office to tell the American people what polls show they already know -- it's necessary.

Big Bureaucracy. Let's talk about big bureaucracy. 12-15 cents of every health dollar a person pays to a private insurance company now goes for bureaucracy. CBO figures it will be only 3 cents of every dollar under H.R. 1200. CBO estimates we would save well over \$50 billion a year in paperwork under single payer. GAO said we could save 10 percent of health costs under single payer -- \$90 billion a year. It makes no sense to maintain a full employment program for health insurance companies when that money could go to care for people.

I'll tell you, Mr. Chairman, my Government Operations Committee wrote the Paperwork Reduction Act in 1980, which is supported by Republicans and Democrats alike. There's no greater vote for paperwork reduction that this House could make than to approve H.R. 1200. It's the biggest paperwork reduction act of all times.

The Clinton and Cooper plans would reduce paperwork barely a shred. Why? Because they keep much of the wasteful insurance bureaucracy in place.

Free Choice of Provider. This is where the President made his biggest mistake. Because he was fearful the business community would not accept the government negotiating provider fees he bought into this unproven and crazy theory of managed competition. Lo and behold managed competition -- whether the Clinton or Cooper variety -- goes for the jugular and tears into the most sacred part of our messed up health care system: a patient's free choice of provider. Everyone gets herded into HMOs or other arrangements that limit physician choice. If you want more choice you have to pay for it, which means a second class health system would serve low-income Americans. H.R. 1200 maintains the current delivery system -- but gives everyone equal access to it. Patients and doctors would all have more autonomy under single payer.

Single payer is not socialized medicine. It's social insurance with private health care.

New taxes. CBO said clearly yesterday that the health premiums in the President's plan are a tax. So, in effect, his plan raises money like we do under H.R. 1200. The Cooper plan makes no bones about taxes -- his plan makes Americans pay taxes on health benefits that they already get for free.

The real issue isn't taxes. It's spending. If we can save a lot more money by centrally collecting with one payer in each state the same money that is already being spent on health care, rather than by using 1,200 different insurance companies, why be bound by some ideological debate over taxes.

Businesses and individuals can pay premiums to an insurance company, and individuals can pay for health care out-of-pocket, thereby continuing the waste and inefficiency of the current system. Or the government can collect that money as taxes and run a more efficient, cost effective system, as we do under H.R. 1200. I have every confidence that the American people can understand this difference, and not be fooled by the self-serving rhetoric from the insurance industry.

Again, the recent Newsweek poll found that by 51 to 41 percent people want employers to pay most costs of coverage. And let's put this employer mandate in perspective. In 1990 Congress increased the minimum wage by 45 cents an hour. We never heard about significant job loss. H.R. 1200 would cost the smallest employers only about 30 cents an hour. But think of how much it would save employers in reduced health spending and healthier workers.

Mr. Chairman, the critical condition of our health care system requires that we do major surgery. Without major surgery the patient -- all Americans -- don't have a chance. I believe we can come together by adopting a program like H.R. 1200, which brings all Americans together under the same high-quality insurance policy.

Chairman STARK. Thank you.
George.

**STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. MILLER. Thank you, Mr. Chairman, and let me thank you and your colleagues on the committee for holding this hearing on H.R. 1200.

As so often is the case in politics, competition between various proposals on a single issue not only sheds great light but also great misunderstanding. The debate over the cost of the competing health care reforms is significant, but it is not determinant. The critical question is not whether the plan is paid for through a tax or through premiums or copayments or deductibles; the critical question is: Does the legislation deliver what it promises, and will it provide quality medical coverage for every citizen that they and our Nation can afford?

The Congressional Budget Office has studied the President's plan and the single-payer alternative. In 1992, it also studied the Cooper plan, the so-called Clinton-Lite. The CBO found that the Cooper plan left 25 million people uninsured by the year 2000 and cost the Nation an additional \$19 billion in health care costs by that same year. It does not reduce costs; it does not provide universal coverage. The Cooper plan, quite frankly, is not a viable option. Rather than being Clinton-Lite, it is really Health Care-Lite.

The CBO analysis of the President's plan should not be feared by the President or his supporters. Being on budget is acceptable and probably advantageous. The CBO that found that while the plan would cost more than the President had thought, it still will generate savings in overall health care costs and ultimately bring down the Federal deficit after the year 2004. The CBO found that the plan would not have a serious negative impact on the economy, and the CBO also stated that we should bear in mind that the short-term deficit created by the plan offers this country a very real benefit—health care for all of its citizens.

What did the CBO find when it studied the single-payer plan? Quite frankly, the single-payer plan wins this particular round of competition. The CBO found that H.R. 1200, our single-payer plan, would reduce national health care spending by between \$114 and \$175 billion per year starting in 2003. The CBO also found that the financing method for H.R. 1200 would, in fact, pay for the generous benefits that the plan prescribes. The single-payer plan will not increase the deficit, because its financing package of payroll and income taxes was written to match the costs of the benefits that it offers.

It is important to note that the taxes levied to pay for health care are a substitute for, not an addition to, the premiums that the consumers pay today. Again, it is not what you call it. But does it add up and does it deliver on its promises? The single-payer plan will offer better benefits to all consumers at cost savings to 75 percent of those Americans.

Bear in mind also that comparing the plans, the single-payer plan offers long-term care. The President's plan and Congressman Cooper's plan do not.

The single-payer plan does not require additional copayments and deductibles in addition to the premiums. The President's plan and Congressman Cooper's plan do.

The President's plan and the single-payer plan specify a detailed list of benefits that would be offered. The Cooper plan has no such list. The only guarantee under the Cooper plan is that your health insurance benefits are going to be taxed for the first time by the Government, unless you go for the lowest possible plan. But there is no guarantee of what the country will receive in return for the tax on your benefits. The Cooper plan, like its neighbor, the Chafee plan, will not meet the test of the American consumer looking for both affordable health care and universal coverage.

Again, we are left with either the President's plan or the single-payer model. And in the final analysis, single payer, as offered by my colleagues, Congressman McDermott, Congressman Conyers and Senator Wellstone, offers a more generous benefit to more people at a greater savings than any other plan.

The single-payer alternative, H.R. 1200, establishes a health care system that preserves the right of every American to select his or her own doctor. It affords every American access to care regardless of his or her employment or medical history. It provides doctors the ability to conduct their profession as they were trained to do, and it treats businesses equally and fairly, eliminating the need to cut employee health benefits as a competitive strategy. It saves money, over \$1,000 per family per year.

What we have witnessed over the past year is that both the President and Representative Cooper have been playing hide-the-ball with the American public with regard to health care costs in this country.

But this committee is far too sophisticated for that. You know the real cost of health care, and you know that we are all paying for it in this country, and that there is no free care. Charitable care, unreimbursed care, shows up somewhere else in the health care expenditures of this country.

The question that we are going to have to ask is: Are we going to rationalize the system of payments and reimbursements and preserve the best of the American system of health care? Are we going to stop the waste, the inefficiencies, and the anxiety of our constituents over their health care future?

If we are, then there is no other choice than the single-payer plan. It is honest; it is straightforward; it is universal; and it preserves the choice of physician. And most importantly, it is paid for, and there is no other alternative that has been put before this committee that does that.

I thank you for the opportunity to testify.

Chairman STARK. Thank you.

In round numbers, let me talk about the most distasteful stuff first.

An 8.5 percent payroll tax raises about \$255 billion a year in round figures? Can you go through these numbers with me?

Mr. McDERMOTT. The actual amount? I do not know the exact amount it raises, because that is not the way we did it. What we did was, we defined the benefit package and asked the Joint Tax

Committee to raise enough money to pay for the costs outlined by CBO. So we did not get into exactly what it would cost.

Chairman STARK. OK. I thought you had gotten to \$500 billion. But what I cannot find is the other \$450 billion that we are now spending. Is that savings? How does that—

Mr. McDERMOTT. Well, there are certain current revenue streams that are maintained. For instance, Medicare continues right on through. So the money that we are raising in Medicare—

Chairman STARK. So 140. And Medicaid, you keep that in, too?

Mr. McDERMOTT. Yes. We keep in 15 percent from the State effort. And so there are other revenue streams that are in that.

Chairman STARK. What I am trying to get to is that yours is arguably the most disastrous news that anybody could dream up in terms of saying: This is what you are going to have to pay. I mean, you come to it, and you and I and Mr. Thomas and Mr. Miller are going to have to pay, if it is a 2 percent income tax, \$2,600 a year. Now currently if we have got—

Mr. McDERMOTT. That is on taxable income, not on the gross.

Chairman STARK. I understand. All right. But let us drop that even to 2. But we are paying \$1,200 now for our share of Blue Cross low option probably, so that is an argument that probably we should. That is a fair amount. I would hate to make the case that \$1,200 is our fair share of the benefits we get for our health insurance.

Now you take somebody who works in my district, who makes \$40,000 gross, maybe they are going to have to pay \$600 or \$50 a month, and they are in a union; they are a teamster, and they do not pay anything. So we have got to look at them and say: Hey, if \$50 is what you are—

Mr. McDERMOTT. If they made taxable \$40,000, 2 percent would be \$800 a year.

Chairman STARK. All right.

Mr. McDERMOTT. A year.

Chairman STARK. So that is \$75. I was a being a little more generous to you.

But at any rate, you do what has to be done. And what the President started out to do, but kind of backslided by hiding all of this, everybody has got to pay something.

Mr. McDERMOTT. Yes.

Chairman STARK. And the question that seems to—and Mr. Reischauer said that yesterday and, George, as you indicated, it is time we got it on the table.

The Roundtable and the U.S. Chamber signed up with the Cooper plan, pledged to support paying \$16 billion a year corporate tax only. That is what they signed up for.

Now the only question is: Is \$16 billion enough out of the corporate? Maybe they ought to pay 30. But at least they are on record. They seem to think that by voting for—by supporting Cooper, it is not going to cost them anything. But it did not. And that is what they signed up for.

What I want to ask either of you is: Do you or anybody else know of any way to provide a comprehensive plan to pay for medical care for every individual in the United States without changing the dol-

lar amount that almost every American company and individual would have to pay?

Now some would pay less; a whole lot would pay more. But has anybody ever suggested that there is a way to accomplish this goal without making some change in the amounts that various people pay?

Mr. McDERMOTT. It is not possible for you not to change the way the present burden is carried.

Chairman STARK. Precisely.

Mr. McDERMOTT. But the fact is that 75 percent would pay less. Well, you will have testimony to that in a short period of time.

Chairman STARK. But that is exactly where the debate ought to be.

Mr. McDERMOTT. Yes.

Chairman STARK. Do poor people pay more? I do not like your plan, if that is the case. Do rich people pay more? If so, sign me up. I mean, the argument ought to be: How much do you pay? How much do I pay? How much will my kids pay?

Mr. MILLER. To do otherwise you are insulting the intelligence of the American people. Come on. There is no poll that indicates that these people thought that this plan, any plan, was going to cost them less. But the question is: What is it we are going to get for this reorganization?

Under single payer, we can show them that they are going to get dramatic efficiencies. They are going to preserve their freedom of choice, and they are going to get a better organization of the payments and the disbursements. And beyond that, there is not much else you can do, if you want to preserve the best of the health care system.

You can try to avoid that and suggest to them, as the President did, that there is this elaborate structure you can create out there, so you never have to say "taxes," that people are really sending their premiums to somebody, but it is not—that is all hokum.

Chairman STARK. I know you do not know much about sports, but it is called a triple reverse.

Mr. MILLER. It is something like that. It is hokum. I mean, it is just—reckoning day was going to come, no matter what, whether it was CBO yesterday or whether it was the deliberations of this committee. And the fact is, if you want to provide universal care, you have got to pay for it.

Mr. McDERMOTT. That was my driving principle in writing this bill. It is partly because I am a physician. And I think if you go to the doctor, you ought to get the truth. And for us to try and put out a health care bill that was not explicit about what was going to happen would ultimately lead to the kind of thing that we got into with catastrophic.

I do not want to create that kind of situation where people think they are going to get one thing, and then they find out about it, and then they are angry about it. I would rather have them know up front how much it is going to cost and what they are going to be guaranteed to get. I think that is the basic way this bill was written.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I think we can agree that somebody who tries to write a universal coverage health care package in which either you can pretend to hide the money on budget or off budget or that you can create a structure which allows you to call it something for a political comfort level does not make a whole lot of sense, and I would refer anyone to chapter 5 of the CBO study, which talks about the alliances and the National Health Care Board and all of the new and novel responsibilities that they have that have to work out of the gate the first time as predicted, or the whole thing comes apart.

So in that sense, I commend you for, you know, truth in packaging, except I cannot give you a gold star, because what you describe basically is something that, if it were true, you would have 435 co-sponsors on it. And the fact of the matter is, you do not, and the reason is, it is not all plus; it is not all more for less, because we have got this equation of cost, choice, and quality, and no one, I think—and as you say, Mr. Miller, quite rightly, we should not disparage the intelligence of the American people.

Nobody thinks that if they are going to get some cost savings in the system, there is not going to be a downside, and it depends on how it is done and where it is done as to whether it is commensurate on choice or quality or both. There has got to be something that gives in the formula of cost, choice, and quality. And you cannot have lower costs, complete choice, and world's best quality as three. You can have two of the three, but you cannot have three.

Mr. MILLER. You can. That is where you—

Mr. THOMAS. I know you think you can.

Mr. MILLER. That is where you are missing the equation. That is where you are missing the equation, because—

Mr. THOMAS. I think you will find that there will be testimony later in the day in which people will extol, for example, the Canadian structure for a number of reasons. But frankly, for certain things important to the American people, more so because of its high death rate, like cancer, you have got rationing, you have got long lines, you have to wait. It is inevitable in terms of a system that begins to be structured along your lines.

But for my purposes, what I need to know—and this is, in part, an exercise that we have gone through here, but I think people need to understand this—you get in this business of universal coverage; nobody is going to have universal coverage instantly; it is going to take time to phase it in just because of the size.

We had testimony from our colleague from Vermont, Bernie Sanders, who said that it is not universal coverage if you do not—if you have any kind of a deductible or a copay; it is not universal coverage. It has to be complete, this is, free.

Now in your bill, you have no out-of-pocket expenses for acute care or preventive services. The President does. So does the President have universal coverage in his package, or is it deficient because of the way in which you have provided, "universal coverage," or does this debate mean anything?

Mr. McDERMOTT. Our bill guarantees universal coverage, and there is no question about it in our bill.

There are some questions you can raise about the President's bill in terms of the subsidies and the ability of the average low-cost

worker to come up with his 20 percent of the premium, those kinds of issues.

And that is what the CBO raised yesterday in their analysis. The President's bill was built on low premiums. The CBO kicked the premiums up, and when you then look at people making minimum wage, their ability to come up with that 20 percent—

Mr. THOMAS. Is much tougher.

Mr. McDERMOTT. If you have not got enough subsidy money, you are going to have some troubles.

Because H.R. 1200 subsidizes those who have not got it on the whole universe of the United States, we guarantee it.

When you are trying to do it on an individual-by-individual basis, it is very clear that some people are going to have some difficulty in the President's plan.

Mr. THOMAS. What about under your plan for those folks who have no acute or preventive services? Is that universal coverage and no cost, or do they have to pay something?

Mr. McDERMOTT. We do not have any copays in our bill. The reason for that—and I am a physician, so I have looked at this whole question about how you deal with copays—you do not want to put on copays that keep people away.

For instance, if somebody has high blood pressure and you want them to come back for monitoring, if you put a \$10 or \$20 copay out there, some people who need to come back and have their blood pressure monitored are going to say: Well, I feel fine; why should I go back? That may be exactly the person that you want to come back, because they are having some kind of high blood pressure situation that you want to monitor.

So you have got to be careful when you try and mold people's behavior by using financial means. You may get an unintended effect.

Mr. THOMAS. CBO, in its analysis—and I am envious of the fact that you have a CBO analysis; we are trying to get one ourselves—

Mr. McDERMOTT. You have to put your bill in early.

Mr. THOMAS. Well, we wanted to see what ideas were out there and offer the best possible package, which, by the way, Mr. Miller, if you have not analyzed the Chafee/Thomas package, it does provide universal coverage and does meet the complaints that you indicated that the Cooper package has.

On page 6, CBO assumes that States would impose copayments or coinsurance for drugs, nursing homes, durables, and home and community-based services.

Do you agree with that under your plan? Do you believe that that is going to occur, or is CBO wrong in its analysis?

Mr. McDERMOTT. There are copayments for long-term care. There presently are. If people are in nursing homes—

Mr. THOMAS. What about drugs?

Mr. McDERMOTT. Not in pharmaceuticals.

Mr. THOMAS. CBO assumes States would impose copayments on drugs, medical durables.

Mr. McDERMOTT. The only copays in our bill are on the long-term care.

Mr. THOMAS. I understand that. But that is from the Federal end of it. They say the States are going to impose them because of the

need to, I assume, ration the use of them because of the fact that there would be an enormous increase in the use.

Mr. McDERMOTT. Mr. Thomas, let me say something.

Mr. THOMAS. The copayments moderate the additional demand for these services because people are going to see them as free and use them a whole lot more.

Do you agree with CBO's analysis?

Mr. McDERMOTT. No.

Mr. THOMAS. You do not?

Mr. McDERMOTT. They gave us the hardest scrubbing of any plan they have ever had put before them, and we still come out better than the President.

They anticipate a 50 percent increase in utilization. They only gave us a 75 percent efficiency in controlling costs at the State level. We did not get any of the benefit of the doubt. And in my opinion——

Mr. THOMAS. Well, then, you should not. When you say that everything is basically going to be free and then say there is not going to be an increased utilization of the services——

Mr. McDERMOTT. But the bottom line is——

Mr. THOMAS. Something has got to give, and that is the point. You cannot have everything.

Mr. McDERMOTT. But the bottom line was, in the end they still gave us more savings than the President's plan with universal coverage.

Mr. THOMAS. I understand.

Mr. MILLER. Increased utilization of services does not necessarily mean that you drive up the overall health care expenditures, because some people will come in where they would not otherwise utilize the service. They will utilize it at a much lower threshold and much less cost, and you will avoid the later high-intensity care.

Mr. THOMAS. I understand. And you folks need to have selective support of the CBO analysis, just as the President does.

Mr. MILLER. No, no, no, no.

Mr. THOMAS. What you need to do is tell me why CBO is wrong in that particular area. But we will be going through that.

Here is a question that I have, because you pretty well indicated that insurance companies have no constituency and that we ought to do away with them, and that your plan does just that.

A lot of times when we pass laws, especially from the tax side of it, you have got a long transition period or a grandfather clause or something to deal with the current world that changes to the new world. And there are a lot of people out there who have prepaid retirement plans through insurance and the rest.

Did you guys contemplate going from today's world to tomorrow's world in which insurance is no longer a private-sector concept——

Mr. MILLER. Sure.

Mr. THOMAS [continuing]. And people do not prepay insurance plans?

Mr. MILLER. Sure. We contemplated that you would contemplate that. And obviously if this committee was to mark up H.R. 1200, it would make some decisions both about the benefit package that we would hope would remain universal and whether or not there are some parts of that benefit package that would be open to some-

thing like a Medigap policy or whether or not there would be a transition period.

Nobody believes that we are going to wake up on January 1 and have universal coverage. But that is a matter of political deliberation. It is not a matter of the plan that we eventually want to see in place.

Eventually our goal would be to see this plan in place without those copayments, deductibles, or additional insurance plans. But to get from A to B, there is no hostility to those approaches at all.

Mr. THOMAS. Well, if that question is going to be left to us, and if we mark up the bill, then I feel comfortable about not having to get an answer to them, because that will not happen.

Thank you, Mr. Chairman.

Mr. MILLER. And the answer is yes. I mean, that is not a problem, if the end of the story is H.R. 1200 with universal coverage and no other out-of-pocket expenses. That would be our goal, absolutely.

Mr. THOMAS. Yes, but then the cost and all of the other problems are far greater as you get—

Mr. MILLER. No, they are not; no, they are not.

Mr. THOMAS. I understand you say that.

Mr. MILLER. You cannot use the CBO, just as you do not want us to use CBO analysis, one way or the other, you cannot either. The fact is, CBO says that when you do it this way, you get the greatest savings, no deficit, and the greatest expansion of health care benefits.

Mr. THOMAS. And there is a downside, and the downside is what has occurred in other countries.

Mr. MILLER. No, no, no, no, no, no.

Mr. THOMAS. I understand you do not believe that.

Mr. MILLER. No, no, no, no, no, no.

Mr. THOMAS. And that this is the best of all possible worlds. I am sorry, but there are negatives. And the negatives are those questions that the American people need to be asked, and that is: Do you want to give up a degree of quality and of choice, and do they want rationing, and do they want to wait in line, and do they want Government to run the program?

Mr. MILLER. Or do they want to sleep in the streets like they do here waiting for their medical care?

Mr. McDERMOTT. May I just make one suggestion? There is an OTA report on the effectiveness of cost-sharing of deductibles, and they do not show any effectiveness. You can deter care. In fact, the Economic Policy Institute says you deter as much needed care as unneeded care. So there are real serious questions about the use of copays as a means of controlling costs.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Let us expand on the last point that Bill Thomas talked about. When we go back home and have our health care meetings and we talk about the single-payer plan, which is the Canadian system in part or in whole, the criticism we get is (a) it is socialized medicine; (b) there is going to be rationing; (c) there are going to be long lines; and (d) if you need the health care in Canada, you run to America.

Those are the things that are oft repeated by my constituents. It is amazing the level of expertise Americans have on the Canadian system. At one townhall meeting I had an RN come forward, and he had moved to this country and is working here now, and he extolled it as the best in the West.

So what do you folks say when you go back to your townhall meetings and you get that type of criticism?

Mr. MILLER. Well, I think as Dr. McDermott has pointed out, I think about 80 percent of the Canadians live along the American border, and the leakage is less than 1 percent by all studies. So the notion that you are going to get knocked down at the gate if you try to go north by people coming south for medical care just is not true.

There is all this sort of anecdotal evidence that people talk about at cocktail parties. It simply is not supported by the evidence.

The other fact is that this system, I think as Congressman Stark pointed out the other day in the committee hearing, that essentially a system very similar to this has been in place in this country for 30 years. It is called the Medicare system. And most of your constituents are not asking you to get rid of Medicare to give them something else. What they really want to know is how can they get more of it. That is the real question for them. And most people hope they get to the threshold where Medicare kicks in.

You hear people kind of go: Whsssh! I am finally eligible for Medicare; I am now safe; I now have my health care taken care of.

For those people in Medicare, the care is not rationed, and they get to choose their physicians. Now we have deductibles; we have Medigap; we have a lot of things that you will have to deal with here. But the fact is, that is the American system of single payer that has been in place. And the fact is that the hospitals and the doctors and everybody do very well with that.

What they cannot take is the Medicare reimbursement and then all the unreimbursed costs or the tremendously low reduction that they get from a program like Medicaid or no cost at all and combine those and run a profitable operation or a self-sustaining operation. But Medicare payments across the board, clearly they could do it.

So we have had this system. And more people are trying to get into the Medicare system than are trying to leave it. People want the age threshold lowered. So, I mean, what you hear against the single payer is cocktail party talk. It simply is not substantiated by the facts either on behalf of the plan or in attacking the Canadian system or the German system or the Australian system.

And this whole business of rationing, you know, Gerry, as well as anybody else, we do it here simply on the basis of the size of your wallet. That is how we ration care in America.

Mr. KLECZKA. Two more questions before my time runs out, George.

The State of Wisconsin has more MRIs than the entirety of Canada. Do you have any cost controls or certificate of need provisions in the bill?

Mr. THOMAS. Sure.

Mr. MCDERMOTT. Our proposal puts the responsibility on the hospital. They are given the money to run their hospital, and they

can buy any MRI they want, as long as they have the money to operate it.

We did not put specific certificate of need provisions in this bill in part because the experience with that whole program across the country has been very, very mixed. Some States had success with it; some had absolutely none.

So we said: Let us let the hospitals manage it. Here is the money for you to run your hospital. If you think you need another one, as they do in Canada—I had people down from the Ottawa General Hospital, and they are putting in a second MRI at the main teaching hospital in Ottawa. The reason? Because the other one is fully used, and they now have an additional need.

And I think the thing that George is talking about, the Canadian system, one of the reasons why they have been able to control their costs is they have bought smart.

When I was an intern at the Buffalo General Hospital, there was often a Canadian patient in one bed and an American patient in the other bed, the Canadian paying two-thirds of what the American was paying, because the Canadians negotiated with Buffalo General to get their health care done there.

It is only 50–60 miles from St. Catherine's down to Buffalo, so it is a very short drive. It is not as though you are sending them 10,000 miles away to get health care. The Canadians have purchased on our side, health care. They do it in Seattle on operations on hearts, heart transplants. And the fact is that the Canadian Government discovered that there are—\$600 million in fraudulent claims by Americans in Ontario alone.

They found that 60,000 people using the Ontario health care plan had American drivers licenses. So they have now had to go to their system and begin to figure out how to put a picture on it, so that they can actually—right now their card is just an orange-and-white card with a number on it and your name, and they have now decided they have got to go to some kind of ID, so that Americans will quit coming across from Windsor and everywhere else to get their health care in Canada.

It is a real problem. It is more going across in that direction than coming this way.

Mr. KLECZKA. That is interesting. Let me give you the \$64,000 question now.

I know full well that your single payer this session will not pass in total. The President has already expressed interest in compromise. Cooper is picking up steam from some segments.

When we start, especially in this subcommittee, putting all of these together to come out with an agreed-upon package that will do the job, what portions of your bill do you think are most important to meld into this compromise version?

Mr. McDERMOTT. We have not seen any reason yet while we should give away anything. We have got better coverage for less cost. We guarantee free choice of provider; it is the only plan that does that, the only plan that gives long-term care, and we do it for less money.

Mr. KLECZKA. Do you cover optician services, because that is lacking in your own—you are kidding me?

Mr. McDERMOTT. Well, we are only five votes short, Gerry. I mean, this process—

Mr. KLECZKA. OK. I guess we do not see things—

Mr. McDERMOTT. Let me raise the question about the Cooper bill, because the Cooper bill, you see, is gaining steam. I do not know how many people really understand in the Congress the tax that is buried in that.

What he gives is deductibility for the lowest-cost plan. Everything else to the corporation is not deductible. And if an employer gives greater benefits to an employee, it has to pay a 34 percent surcharge.

Now that is going to drive employers to push those costs onto individuals, and individuals cannot deduct it. It is going to be after-tax dollars, which is an income tax on individuals in this country.

If I were running against him or anybody who supported that bill, I would eat them alive.

Mr. KLECZKA. Let me see if George has a more compromising—

Mr. McDERMOTT. Taking away deductibility on insurance benefits.

Mr. THOMAS. I think the burden is on the other foot, and that is this, that they have got to come up with a plan that is superior to the existing one. And so far, they have not.

The President has taken away all your choice; Cooper has taken away all your choice. They have raised a lot of money, and they still do not quite get to the question of quality care and universality. And that is the problem.

And before we trade this one in, you know, we are not so eager here to trade the current system in. We think there are overwhelming problems, but as we constantly have pointed out to us, the vast majority of Americans are essentially happy with it. They do not like the insurance companies, but they essentially have their coverage.

Now we are trying to expand the pie to a lot of people who need it, who get cannot get it for a whole lot of circumstances. But before we trade it in, we want to see that something better is coming through the door.

Right now, ours is the only proposal that improves upon that. All the rest of them kind of rearrange the deck chairs here, but the system is still going to the bottom of the ocean, and it is not going to be saleable.

Cooper is going to get his turn in the barrel. The President had his turn in the barrel, and he did not come out so well. Now Cooper is going to go in the barrel, and people are going to start analyzing the kinds of tax increases that are going to through for no listed benefits, and then we will see where the Congress is. This is going to look better and better.

Mr. KLECZKA. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

I admire your tenacity, but—

Mr. McDERMOTT. I would wish you would admire the plan.

Mr. LEVIN. But let me just tell you how it plays in a district—the district that I represent, which in many respects is pretty typical.

There is, I think, deep antipathy toward at least two aspects, of the single-payer plan. First, there is deep skepticism about shifting the funding to the tax system.

Second, there is a deep, if not hostility, at least a deep questioning about a major enhancement of the role of the Federal Government.

And I think that the public's antipathy toward use of the tax system and having, in quotes, the government run it, is reflected in a recent poll that says these feelings are true not only in Macomb and Oakland Counties, Mich. but across the country. This was from a poll taken by the Robert Wood Johnson Foundation, and maybe you saw the report. I do not think they have an ax to grind. The poll was taken for them by the Harvard School of Public Health and the Princeton Survey Research Associates.

It showed first of all that we have a long ways to go to really explain any plan to the American people. A lot of people do not know the details or really the major contours of any of the proposals.

But when the various plans, or at least some of them, were read to the 1,000-plus who were sampled, here is the way it came out: 40 percent said they would choose a plan like President Clinton's, requiring employers to pay, while 19 percent they would prefer a Canadian-style plan.

Mr. MILLER. Well, Mr. Levin, I think, you know, we, those of us who are supporting single payer, are into a marketing nightmare. To go around and ask people if they want single-payer or a Canadian system—Americans are not big on foreign—

Mr. LEVIN. But that really is not the way it was asked.

Mr. MILLER. But let me—no. The point is, you said there is a deep skepticism about shifting the cost to the tax system and about—what was the second one, the—

Mr. LEVIN. And a major enhanced role of the government running it.

Mr. MILLER. Ask your constituents if they have those concerns about the existing system, which is Medicare, where they all pay a payroll tax, and the Government runs the Medicare system. So, you know, you have got to ask the question. We do not have the luxury of asking that about Medicare. We have the luxury of asking about single payer or a Canadian system.

But the fact is, the most popular plan in the country is the Medicare system, and it is done on a payroll basis. The question is: What is the rate of tax, and are other people going to be covered by it?

So you have got to, you know—as we all know from polling in our business—you have got to ask the question right. Go back and ask those same people about whether or not they like the benefits of Medicare, where they get freedom of choice, it is paid for, and all they do is hand their card across the counter.

Now some hospitals, some doctors, do not like the reimbursement rate, but you have dealt with that now for the last 30 years on this committee. And so that is the system. That is the system.

Now whether or not you have, as I say—whether or not you continue deductibles or copayments or Medigap policies, the fact is that is the American single-payer system, and it is hugely popular, as

we know every time we suggest we are going to touch it. It is the hottest stove in town. Nobody can carry it more than, you know, more than a second if they suggest that someone how they are going to deny people access to or benefits under Medicare.

Mr. LEVIN. All right. But let me just tell you that I think you are right about the basic popularity of the Medicare system for covering seniors.

But the dilemma that you face and this Congress faces and the President faces and all America faces is that people know they have a Medicare—there is a Medicare system for seniors.

When you ask them if we want to spread a single-payer system to all America and end the private role for insurance for everybody and shift the entire burden of health care from the private to the public arena, the answer is no.

Mr. McDERMOTT. But that is a mischaracterization. You are talking about financing. Every other plan, including the President's, takes the delivery system in this country and stands it on its head, and it drives people into HMOs by financial incentives.

Ours is the only plan that says to the American people: You can still see your same own doctor; you can go to the same hospitals and every other thing. The only thing we are going to fix is the financing system.

Mr. LEVIN. All right. Let me just say—

Mr. McDERMOTT. The President keeps the financing system. He keeps the insurance companies and stands the delivery system on its head. And that is why when you take that home to people, you are going to get chewed up. That is why I will not vote for that kind of thing that uses financial levers to force people into a delivery system.

Mr. LEVIN. Yes, but I am opposed to doing that, and to—

Mr. McDERMOTT. That is what the President's plan does.

Mr. LEVIN. I do not think it does so nearly to the extent that the Cooper plan does.

Mr. McDERMOTT. That is true. You are absolutely correct. The worst is Cooper.

Mr. LEVIN. And lurking behind the Cooper plan is a basic effort to push people into HMOs.

I am in favor of retaining the choice, a meaningful choice, for Americans, but they want choice and—they want choice and a mixed system in terms of funding, and they do not want the government to run it all.

Mr. McDERMOTT. Again, let me go back—I will take you back to the best model we have in the country. I will go back to Medicare.

Senior citizens get to go to—in my district, they go to HMOs; they go to fee-for-service doctors; they do to some combination or in between. If they belong to one, they get referred to another. They design their own medical care under Medicare. And the private sector is involved because there are some things that Medicare decided it will not cover, and that is under your Medigap, long-term care and others.

So this is not strange. The problem you describe is relatively easily solved and understandably so, which is the big trick in this business.

Mr. LEVIN. Well, most Americans want retention of the Medicare system for seniors. They do not want that model applied universally, uniformly.

Mr. McDERMOTT. There is no evidence that that is the case.

Mr. LEVIN. Wait a minute. Giving people no option other than that.

Mr. McDERMOTT. There is every option.

Mr. LEVIN. I mean, that is the meaning of this poll. People know there is a Medicare system. But when you ask them: Do you want that to be the single system for this country, the answer is no.

Chairman STARK. Mr. McCrery.

Mr. McCRERY. Thank you, Mr. Chairman.

I want to say that I think your plan, Mr. McDermott, and the single-payer concept is a legitimate way to address the issue of spiraling costs in the health care system in this country. And I applaud you for coming forward with the plan and putting it out there as one of the possibilities for reforming our system, particularly the payment system.

I do not agree with your plan because I do think it has some effects on the system that you have not talked about too much, and we will hear more about those effects later this morning. And Mr. Miller denied that there were a lot of those bad effects, but I happen to think that there will be rationing. And it is true we do have rationing today, and we are always going to have some kind of rationing; otherwise, costs would go through the roof even more than they are today. But I do think yours is a legitimate way to address the system, and it is an option that should be considered.

Mr. Miller has continually compared your plan to the Medicare system and holds up the Medicare system as being the most popular part of our health care system and so why shouldn't we just kind of enlarge that and make the whole system a Medicare system.

Is, in fact, your system basically that? Would your plan basically just be a big Medicare system?

Mr. McDERMOTT. The way our system is designed in the bill, the Federal Government decides the benefit package—we wrote it into the bill—and we collect the money on the basis of a payroll tax. So you now have a Federal health care trust of money.

The money is then apportioned to the States according to population and previous spending patterns, and there are some differences in this country, and it is very hard to iron all those out. You cannot make the same system for everywhere. Louisiana is different than Washington State or Vermont or New York State.

So we said let's put it down at the State level for the administration, and the delivery system changes. The reason is I was a State legislator for 15 years, and I have been catching cannon balls from this town that whole time. Bills always work for California, New York, Texas, and Florida, and the rest of us are out there trying to figure out, "Who thought this up?" So I said if I am going to put a health care plan out there, I am going to let the States decide how it ought to be delivered.

Now, there will be more HMO activity in the State of Washington and in the State of California than there will be in Louisiana. No question about it. We have a long history, long experience with

it. So we wanted to have those kinds of decisions made at the State level with a fixed amount of money that was collected from the payroll tax, and that then you would decide how in Louisiana will you deliver this benefit package to everybody in Louisiana. It would be done using private doctors and private hospitals, as it presently is today, and that is the basic structure of how it would work.

Mr. MCCRERY. So it is very similar to the Medicare system?

Mr. McDERMOTT. Except that it is controlled at the local level rather than the Medicare system, which is at the Federal level. And that is an important decision.

I think Mr. Stark and I probably would have a discussion. He would favor more a single-payer system like the Medicare system all done in Washington, D.C., or Baltimore. I believe that more of those decisions should be made down at the State level. That is a political judgment that obviously we in the Congress will make.

The President has put a lot of State options into his. He allows for a single-payer option at the State level, and this is really a political argument about where the control is going to be. And I tend to think the closer it is down to where you are delivering the service, the better off you are. To speak for Mr. Stark and maybe for some people, they think that you will get inequities in the States, and some States may not do it so you have to do it at the Federal level. But we can iron that argument out.

Mr. MCCRERY. Well, before my time is up, let me encourage Mr. Miller—and you can respond to this, if you like—to maybe get another model for holding out for examination than the Medicare system. One reason the Medicare system is so popular is because people get a lot more than they pay for. The Medicare system spends a lot more money than it takes in, so people are getting a lot more than they are paying for. And I do not think that is the way you want the entire system to be; otherwise, the Federal deficit just goes completely out of control. Some would say it is completely out of control now, but certainly the Medicare budget is part of the budget problem in this country. So I think that is one reason Medicare is so popular, is people get a lot more than what they pay for.

I assume under your system you would try to equalize revenues and outgo, and it might not be as popular then when people have to actually pay for everything they get.

Mr. MILLER. To respond quickly, the reason our payroll tax is set at the level that it is is because of the genius of Congressman McDermott's request: This is the package that we want to present to the American people; now what is the money we need to finance this? So CBO says we do not create a deficit because, in fact, that package of benefits is paid for.

Now, that might be too rich for the Congress or for this committee or for the American people. That is open to adjustment. But we did not do it the other way.

Mr. MCCRERY. Sure.

Mr. MILLER. The other way is to try to fudge the issue as we have seen now for the last year.

Mr. MCCRERY. With the Medicare system, and I appreciate that, and I applaud you for that. But I think the analogy with Medicare breaks down on that basis.

Mr. McDERMOTT. I do not think any of us would say that the Medicare system has been without problems because in some ways Medicare is just another insurance company, and Medicare is doing what everybody else does, which is try and shift the cost to somebody else.

When I was a State Ways and Means Chairman in the Senate, I used to take the request for Medicaid and cut it in half. And if you had asked me why I did that, I would say, well, I need money to pay for the University of Washington, for the Fisheries Department and the State Patrol, and I know that I can shift those costs on to Boeing and to Weyerhaeuser and to U.S. West and all the other companies in my State.

Everybody has been doing that in this present system. In a single-payer system, there is no place to shift it. You have everybody in the same bag.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Mr. Chairman, I am delighted to see two of our colleagues, Mr. McDermott and Mr. Miller, here today.

Up front I must say, Dr. McDermott, I am very proud to be a cosponsor and a supporter of single payer. I know in our efforts to reform the health care system, we should come up with a system that will be accessible to everyone. No one must be left out and left behind.

With the Cooper plan, with the President's proposal and some of the others that are floating around, I have been deeply concerned that we will have a continuation of redlining by insurance companies and by some health providers. We would segregate people, gerrymand people.

Tell me what would happen under single payer.

Mr. McDERMOTT. Under a single-payer system, everyone would have a health care card that would be usable with any physician or any hospital that the patient would choose.

One of the difficulties in looking at our health care delivery system today is that 35 percent of the people live either in rural areas or in inner cities, both of which are chronically underserved for their health care needs. And the main problem that you have in trying to set up a practice either in a rural area or in an inner city is that most of the people do not have insurance. You find the uninsured clustered in these areas, and the fact is that because they do not have the ability to pay, if you were to open a practice there, the people coming in would be unable to pay for their health care. And so people do not choose to go into those areas.

If you have everybody with a card, that is, equal access, the ability to go in and purchase health care, it would be possible then to recruit people into those areas, and you will begin to see a shift in the way the system operates.

I think that all you have to do is look at Mr. Reynolds' district in Chicago. There is not a single emergency room open in his district. No hospital has an emergency room open in that district in Chicago.

Now, that kind of thing will only be dealt within a single-payer system that says that everybody who comes to the hospital has the

ability to pay because they have their card, their universal American health security access card.

Mr. LEWIS. Mr. Miller, would you like to comment?

Mr. MILLER. Well, I think that is it. It is the portability of the care. Today if you belong to various plans, you have got to call an 800 number if you are out of State, if you are out of city, if you are outside of that plan. Will you be reimbursed? If you do not make that call, additional tasks are put on you. But clearly, that is just the problems of not having a single system.

But it also goes to the question of inclusion. If you read all of these other plans very carefully, there is a very large question raised about what happens to what we now consider public medicine. The people in our inner cities, people with TB, people with AIDS, and people with no insurance and no prospect of getting insurance, what really happens to them?

Well, there is some notion that they will eventually all sort of transition into one of these alliances or one of these plans. But the question is, even among the alliances, do the alliances want to come in and serve these areas? Are the alliances going to be drawn in such a way so it does not take in the District of Columbia or Manhattan or the city of San Francisco or southeast L.A.? Those kinds of issues are being raised.

That is all, again, because you are trying to fool people about what the real total national bill is for health care. As long as you try to do that, then you have to try to shave and manipulate the system not based upon delivering health care to people and then paying for it. And the concern that you raise here is, I think, a very, very real concern in each and every one of these plans because at some point, under all the other plans, you are going to decide that you simply are not going to extend coverage in one fashion or another and we are going to have constituents that continue to drop through the gaps in those plans. And that is, again, the value of the single-payer system.

Mr. LEWIS. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

First, I want to congratulate my colleagues for having the courage, as the President did, to come forward with a proposal that would provide universal coverage for every American and have enforceable cost containment in your legislation. I look at the CBO testimony from yesterday as indicating that we now have in the House of Representatives two proposals before us that would provide universal coverage and would bring down the cost of health care: Your proposal—the single-payer proposal—and the President's proposal.

What concerns me about having one payer, a Medicare-type system, is that I do not think the Medicare system is very rational in the way that it reimburses for health care in this country. I do not think it makes an awful lot of sense.

I have talked to many health care providers, particularly those who want to locate in communities where there is a large number of elderly, who tell me it is difficult to do that under the current system, that the doctors and the hospitals want to locate in subur-

ban areas where they have a significant percentage of their payment in private pay in order to shift costs.

You see, we shift costs in our society today. And there is a concern that if we have only one payment system that it is not going to pay the fair amount or the rational amount or that a political body such as this committee or the State legislature will be very political in the way that it determines how those dollars will be allocated. And the bottom line is that we jeopardize quality.

I guess that is my major concern on a single-payer system: Whether we run the risk of jeopardizing quality through diversity and the protection of having different systems out there to offer the incentives for developing new ways of providing health care to our constituents in a more cost-effective way.

So how do you overcome my concern in a single-payer system that we will not run into a budget crisis here in Washington so we, therefore, just cut the budget or we cut certain parts of the budget or that we do things like that; whereas, in a diversified system, such as suggested by President Clinton, we at least have the protection of having different models out there to see how they work in different times and hopefully we get the best from each of the proposals that are out there?

Mr. McDERMOTT. You raise the question of will the budget be short and, therefore, we will cut it. The money that is raised by the payroll tax goes into a health care trust, and it is used for the health care of the country.

One of Canada's problems is that they mix their health care dollars in with everything else. It is just general fund money. And so they are now in an economic depression. And so they are making cuts, and they are making cuts in health care to put roads in or whatever. In those kinds of decisions, the health care system does stand the risk of quality being dealt with. The reason, then, for having a trust is that you have the money and it is going to go there.

Now, the other question of quality, I come back to this: Who do you trust? Do you trust the insurance companies or do you trust the political system to guarantee your quality? And you can say neither one of those is a good choice, but that is the only two choices you have.

Mr. CARDIN. Jim, let me try to throw out perhaps a model that builds upon what you are suggesting and maybe we will see which system works best. Why not pick a market today, perhaps the small-employer market, where we do not have effective competition, and say, look, we will allow that market to have access to a public insurance program without any government subsidies at all, and let that market compete with the private marketplace; and then we will see whether government is more cost effective or whether the private sector is more cost effective in developing a way to finance that type of health care plan.

Mr. McDERMOTT. You are suggesting letting small employers buy into Medicare, for instance?

Mr. CARDIN. Well, into a public—not Medicare because you do not want it to be the same risk pool. Have an opportunity to buy, with no government subsidies at all, a Medicare-type plan, and then let the private sector also be able to sell insurance to that

same marketplace, and then we will see who is more cost effective and who can come up with the better plans and who the consumers like best, whether they like a government plan better or they like a private plan better.

Wouldn't that sort of build on your model? Then we can see—

Mr. McDERMOTT. My only problem with that, Mr. Cardin, is that you are keeping in—or you are giving away the \$100 billion in administrative savings that CBO said we can get by going to a single-payer system.

Now, if the Congress decides that they want to keep the private insurance industry in and they are willing to spend \$100 billion more a year to do that, if they think that is worth an experiment, I personally say more power to you if that is the way you want to spend your money. I do not want to spend my money that way.

Chairman STARK. Would you yield on that point?

Mr. CARDIN. Yes, I yield.

Chairman STARK. If you add uniform payment structures and you have, whatever it is, a uniform cost containment system, if not prices, then the only uncontrolled costs of any major significance would be the overhead of the private insurance companies, which would be picked up by private payers. And my theory is that if people choose to support their brother-in-law who is selling insurance for Aetna, be my guest.

Now, one would think that a rational public would soon figure that scam out and find a better way to put their brother-in-law to work. But, basically, only a third of any savings in any program comes in what would be public plans like Medicare and Medicaid, and two-thirds of the savings goes to private industry.

If they have the option and we put all of the systematic savings that we can, like universal electronic transfer and so forth, then I think the difference between you and Mr. Cardin is that the ABC Corporation and its employees decide they want to stay with Prudential and pay Prudential's 30 percent overhead. And I say if that is the fight we have, be my guest.

Mr. CARDIN. But remember, Mr. Chairman, just to clarify that, there are two parts to the cost of health care. One is the administrative cost; the other is delivery system. And there is at least a belief by some of us that the private sector can be energized to develop a more cost-effective delivery system better than just having one.

Chairman STARK. But that happens under Mr. McDermott's plan where he will pay privately run managed-care systems now. So both your suggestion and Mr. McDermott's would have that opportunity.

Mr. CARDIN. What I am suggesting is that we might want to test that and see what comes out.

Mr. McDERMOTT. I would just say, Mr. Cardin, that you probably better than most know that the single-payer system and the all-payer system are not very different. Maryland has the all-payer system. It has the hospital that is considered to be number one in the United States, Johns Hopkins, which operates in an all-payer system. So the fact that people want to talk about some diminution of quality clearly under a single-payer, all-payer system, which is—I mean, the differences are very minimal.

Mr. CARDIN. But, remember, you can have an all-payer system without a single source of funding, as we do in Maryland, as long as everybody—

Mr. McDERMOTT. We simply make one source of funding, and then you will have an all-payer system.

Mr. CARDIN. Right. But you could very well expand upon an all-payer system in a multiple-payer concept.

Mr. McDERMOTT. I just do not want to pay the administrative costs of insurance companies. Thank you.

Chairman STARK. Is there further inquiry of our distinguished witnesses?

Mr. THOMAS. Just briefly.

In terms of the genius, as my colleague from California said, of asking CBO to price or to figure a mechanism for funding the benefit package, I think when you asked would you rather have insurance companies or the government do it, there was a degree of snickering out there in terms of the choice. It is because if, in fact, we run your system the same way—that is, the benefit package drives what is charged and it is a political decision as to what is in the benefits package—I do not think anybody is comfortable with a system in which this committee or any other committee in essence has the ability to define a benefits package because it turns into a political football. And I think you are seeing, to a certain extent, that today in Germany in which political elections turns on “health care issues” and that people are going to wind up promising that if they get elected, they are going to add something to the benefit package, and you now have a pure political football in the benefits package.

But the beauty of your system, I think you would agree, is that you have got a forced mechanism to fund it, and that is the nightmare, I think, that most people are concerned about.

Mr. McDERMOTT. You absolutely put your finger on the issue. You have a system that is decided in a democratic means, out in front, in public, and if I vote for additional benefits for the people, then I have to step up and vote for the taxes. That is, to me, true accountability, and that is what I think has been missing in our present system—no accountability.

Mr. THOMAS. I agree with you. In our plan, what we say is that if we are going to make savings in the Federal Government programs, the Chafee-Thomas bill, that we are going to fund the expansion to universal coverage after you make the savings, not before.

Thank you.

Mr. McCRERY. Mr. Chairman, just briefly.

Mr. McDermott, I listened with interest to your plan to put all these moneys into a trust fund separate so they will not be commingled with the rest of the budget. And I have not looked at your design, but I hope it is designed better than trust funds that we have included in the Federal budget in the past, which we have seen have not been too successful in keeping from being commingled with other funds.

Mr. LEVIN [presiding]. I am sure that will be taken into account.

Well, thank you. Your forthright testimony, our two colleagues, have been very helpful. You can tell by the engaged discussion.

Mr. Miller, thank you for all this time, and, Mr. McDermott, thank you for going on the other side of the table.

Mr. LEVIN. We will have our second panel now. Unfortunately, two of the witnesses have been unable to attend because of the weather—one, Dr. Hsiao from Harvard. There are, I think, a dozen inches of snow up there. And also Dr. Dans has been unable to join us. But Gerry Anderson is here and Lisa Priest, if you would join us.

Dr. Anderson is the director of the Center for Hospital Finance and Management at Johns Hopkins, and Lisa Priest is a distinguished journalist with the Toronto Star. There has been much mention of our neighbor to the north.

Mr. CARDIN. Mr. Chairman, before we begin, if I might, Dr. McDermott paid a compliment to Johns Hopkins, and I think part of that credit is deserved by Dr. Anderson, who does an outstanding job for us in hospital finance and management at Hopkins and has really been a great help to me personally in helping me on health care issues. It is a pleasure to have Dr. Anderson before our committee.

Mr. LEVIN. Well, I guess we are going to go alphabetically instead of in a chivalrous way. So, Dr. Anderson, if you would lead off?

STATEMENT OF GERARD ANDERSON, PH.D., DIRECTOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT; CODIRECTOR, PROGRAM FOR MEDICAL PRACTICE AND TECHNOLOGY ASSESSMENT; AND ASSOCIATE PROFESSOR OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

Mr. ANDERSON. Thank you very much, Mr. Chairman and Mr. Cardin.

What I would like to do is mention very briefly four design and coverage provisions which distinguish H.R. 1200 from most of the other bills, and then discuss in much more detail the cost containment and financing aspects of the legislation. Specifically what I want to do today that is not in my written testimony is compare the financing of H.R. 1200 to the President's bill. Given the work that you did yesterday, I can now compare the financing in H.R. 1200 to H.R. 3600.

Basically this legislation provides universal, mandatory health insurance coverage for all citizens and legal residents. It is a comprehensive, explicitly defined benefit package covering primary care, acute care, long-term care, and mental health benefits. It integrates Medicare and Medicaid into a single plan. And it does so at much lower administrative costs.

According to the Congressional Budget Office, the administrative costs will drop from 7 percent of health spending to 3.5 percent of health spending by the year 2000. In addition, the Congressional Budget Office estimates that hospitals and other providers will save 6 percent of revenue by dealing with only one payer.

What I have worked on, however, is the financing and cost containment aspects of H.R. 1200. By 1997, the American Health Security Act will rechannel approximately \$500 billion from the pri-

vate sector to the Federal Government by eliminating private sector financing of health insurance and replacing it with an 8.4 percent payroll tax except for small firms with low-wage workers, a 2.1 percent payroll tax, and tax increases on cigarettes and handguns.

Since I did my prepared testimony, I had a chance to look at the Congressional Budget Office estimates, and what I have been able to do is to compare the financing for a variety of families under H.R. 1200 to H.R. 3600.

Let me compare three different two-parent families: One earning \$100,000, one earning \$50,000, and one earning \$20,000.

Beginning with the family earning \$100,000, let's assume that they work in a large firm where the average wage is \$50,000. The employer would pay 8.4 percent of the average wage in the firm, or \$4,200, and the employee would pay 2.1 percent of their adjusted gross income—assuming right now somebody earning \$100,000 doesn't have a lot of deductions and their adjusted gross income is \$80,000—\$1,680. This is a total of \$5,880 or about 6 percent of their total income. It offers comprehensive coverage, no cost sharing.

Under the President's plan, the premium alone would be, according to the Washington Post today, for that same family of four, \$5,565 in 1994. Inflating that at 4 percent per year to get it to 1999, it would be \$6,678, or approximately 7 percent of their income. So somebody earning \$100,000 is going to pay more under the President's plan than they will under Mr. McDermott's plan.

Moving to somebody earning \$50,000, again, where everybody earns \$50,000 in the firm, the employer pays 8.4 percent of payroll, \$4,200. The employee pays 2.1 percent of their adjusted gross income, or, as I estimate it, somebody earning \$40,000 in adjusted income, would pay \$840. Combined, this is a tax of a little over \$5,000, or 10 percent of their income. Whereas, the President's plan they would pay the same amount as before, \$6,678, or more than 12 percent of their income.

For somebody earning \$20,000 or less, they would even pay a higher percentage, although that is much more difficult to calculate.

So as you can see, basically most of the Americans will pay less under H.R. 1200 than they will pay under H.R. 3600.

H.R. 1200 does do this by working on rate-setting and a variety of mechanisms to control health care costs, such as in Maryland, that have worked successfully, and they do it by controlling the National and State budgets. A global budget has been used by other countries for years without access or quality problems.

In the United States, a number of States, including Maryland, have used a form of global budgeting to set hospital rates without adverse impacts on quality of care or access to care, and Medicare currently uses a form of global budgeting for physician services.

So what I conclude is that global budgets make sense. As a society, we decide how much to spend on defense, space, public education through the budget process; no reason why we could not do exactly the same thing in the health care system.

Thank you very much.

[The prepared statement and attachments follow:]

JOHNS HOPKINS

HEALTH INSTITUTIONS

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Mr. Chairman, my name is Gerard Anderson, and I am the Director of the Johns Hopkins Center for Hospital Finance and Management, co-Director of the Johns Hopkins Program for Medical Practice and Technology Assessment, and an Associate Professor of Health Policy and Management at the Johns Hopkins School of Hygiene and Public Health.

Today, I wish to speak in favor of H.R. 1200, the "American Health Security Act." The Act contains numerous provisions that should be incorporated into the final health care reform legislation. There are four coverage and design provisions that warrant special mention:

- Universal, mandatory health insurance coverage for all citizens and legal residents. Many of the other bills under consideration do not achieve this minimum standard.
- A comprehensive, explicitly defined benefit package covering primary care, acute care, long term care, and mental health benefits. The American Health Security Act is able to provide these comprehensive health benefits without instituting cost sharing.
- Integration of the Medicare and Medicaid programs into one comprehensive plan. Maintenance of two or more health care financing systems will increase administrative costs without improving the health status of any American.
- Much lower administrative costs. According to the Congressional Budget Office, the administrative costs under the American Health Care Security Act will decrease from the current 7 percent of health spending to 3.5 percent by the year 2000. CBO also estimates that hospitals, physicians, home health agencies, and other health care professionals would save 6 percent of revenue by dealing with only one payer and eliminating copayments and other billing arrangements.

Financing and Cost Containment

The most controversial and innovative aspects of the American Health Security Act, however, involve its financing and cost containment provisions. In my testimony this morning, I would like to concentrate on three specific issues:

- Shifting the method of financing from the private to the public sector.
- Using price regulation to control health expenditures.
- Using state and national global budgets to contain health care expenditures.

Public Financing

In 1997, the American Health Security Act will rechannel approximately \$500 billion from the private sector to the federal government by eliminating private sector financing of health insurance and replacing the funds with an 8.4 percent payroll tax, a 2.1 percent income tax, and tax increases on cigarettes and alcohol. While many pundits have suggested that such a large tax increase makes this proposal dead on arrival, the method of financing a single payer plan has considerable merit after reviewing the data and comparing it to the current method of financing health care.

In 1997, 75 percent of Americans who are currently insured would pay less for health insurance under the American Health Security Act than under current law and this percentage would increase as the cost savings projected under the American Health Security Act would increase. According to projections made by the Congressional Budget Office, the American Health Care Security Act would save \$114 billion in the year 2003 and, therefore, the average American family would pay over \$1000 less for health care services in the year 2003 compared to current law.

I have prepared a series of charts that illustrate how the financing system would affect individual Americans. The charts show that under the American Health Security Act most Americans would pay less than they are currently paying for health care. For low income individuals and individual with chronic illnesses the amounts would be significantly less. The charts also show that most employers would pay less if the American Health Security Act were passed. The charts are based upon numbers generated by the Congressional Budget Office, Joint Committee on Taxation, Employee Benefits Research Institute, and the National Medical Expenditure Series.

Price Regulation

Under the American Health Security Act, hospitals and nursing homes will be paid on the basis of global budgets. Physicians and other health care professionals will be paid based on a variety of mechanisms including annual operating budgets, fee schedules, and capitation payments.

While no one prefers price regulation to a free market solution, international and domestic evaluations of price regulation in the health care industry have shown that price regulation is able to control costs without an adverse impact on either access to or quality of medical care. In 1991, I wrote an article in the Health Care Financing Review summarizing the published literature on all payer rate setting. The article reached the following conclusions:

- States with all payer rate setting programs have been able to consistently lower the rate of increase in hospital expenditures by 2-4 percentage points per year compared to other states.
- All payer rate setting programs have been able to reduce the extent of cost shifting considerably.
- All payer rate setting programs have increased access for the uninsured because they compensate hospitals for the care of people without health insurance.
- Most studies have found no evidence that quality of care declined under all payer rate setting programs.
- HMOs and other managed care organizations have prospered in states with all payer rate setting.

- The diffusion of new technology and access to capital is comparable in states with and without all payer rate setting.

The Prospective Payment Assessment Commission, the Physician Payment Review Commission, and the Congressional Budget Office have recently conducted independent assessments of the feasibility of regulating hospital and physician services based upon Medicare payment rules. They all concluded that a national payment rate is feasible at this time.

State and National Budgets

The American Health Security Act establishes an annual global budget for health care, limiting growth in expenditures to the rate of growth in the gross domestic product. Each state is given a global budget which the state will use to set budgets for physicians, hospitals, and nursing homes. Separate budgets for new construction, renovation, and major capital equipment are allocated directly by the states. A National Health Board negotiates prescription drug prices with drug companies.

Global budgets have been used by other countries for years without access or quality problems. In the United States, a number of states have, for years, used a form of global budgeting - prospective rates with volume adjustments - to set hospital rates without adverse effects on quality of care or access to care. Medicare currently uses a form of global budgeting for physician services.

Global budgets also make common sense. As a society we decide how much we want to spend on defense, space exploration, or public education through the budget process. There is no reason why the same process could not be used to decide how much to spend on health care.

I would be happy to answer any questions.

SCENARIO 1

WORKER IN SMALL MANUFACTURING COMPANY

Demographics:

1	Age:	45
2	Gender:	Male
3	Family:	Wife and two children
4	Health Status:	No preexisting conditions No long term health care needs
5	Income:	Wages - \$50,000 In 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	Comprehensive benefits; no deductibles; Rx drugs with copay; no dental; no long term care
2	Coverage:	Family
3	Employer Payment:	Employer pays 100% of premium

COST TO THE WORKER

	<u>Out of Pocket</u>	<u>Premium</u>	<u>Taxes</u>	<u>Total</u>
Current System	200 ⁽¹⁾	5435 ⁽³⁾	0	5635
American Health Care Security Act	0 ⁽²⁾	0	5250 ⁽⁴⁾	5250

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NIMES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.87 percent of payroll in manufacturing firms with fewer than 10 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative assumption is that this percentage will not change.

⁽⁴⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent and income tax of 2.1 percent would raise the required amount of revenue.

COST TO THE EMPLOYER

Payments for Health
Insurance

Current System	5435 ⁽²⁾
American Health Care Security Act	4200 ⁽³⁾

⁽¹⁾ Assumes the average payroll in 1999 is \$50,000.

⁽²⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.87 percent of payroll in manufacturing firms with fewer than 10 employees.

⁽³⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent.

SCENARIO 2

WORKER IN MEDIUM SIZED TRANSPORTATION FIRM

Demographics:

1	Age:	42
2	Gender:	Female
3	Family:	Divorced, two children
4	Health Status:	No preexisting conditions No long term health care needs
5	Income:	\$20,000 in 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	\$1000 family deductible; no Rx; no dental; no vision
2	Coverage:	Family
3	Employer Payment:	Employer pays 80% of premium

COST TO THE WORKER

	<u>Out of Pocket</u>	<u>Premium</u>	<u>Taxes</u>	<u>Total</u>
Current System	3330 ⁽¹⁾	2130 ⁽³⁾	0	5460
American Health Care Security Act	0 ⁽²⁾	0	800 ⁽⁴⁾	800

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NIMES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.65 percent of payroll in a transportation firm of between 25 and 99 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative estimate is that this percentage will not change.

⁽⁴⁾ For employers of less than 75 full time equivalent employees earning an average wage of less than \$24,000, the Joint Committee on Taxation has projected a tax rate of 4.0 percent would raise the required amount of revenue.

COST TO THE EMPLOYER

Payments for Health
Insurance

Current System	2130 ⁽²⁾
American Health Care Security Act	800 ⁽³⁾

⁽¹⁾ Assumes the average payroll in 1999 is \$20,000.

⁽²⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 10.65 percent of payroll in a transportation firm of between 25 and 99 employees.

⁽³⁾ For employers of less than 75 full time equivalent employees earning an average wage of less than \$24,000, the Joint Committee on Taxation has projected a tax rate of 4.0 percent would raise the required amount of revenue.

SCENARIO 3

WORKER IN LARGE CONSUMER PRODUCTS FIRM

Demographics:

1	Age:	58
2	Gender:	Male
3	Family:	Married with no dependents
4	Health Status:	No preexisting conditions No long term health care needs
5	Income:	\$60,000 in 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	Comprehensive; \$200 deductible; drugs; dental; vision
2	Coverage:	Family
3	Employer Payment:	Employer pays 100% of premium

COST TO THE WORKER

	<u>Out of Pocket</u>	<u>Premium</u>	<u>Taxes</u>	<u>Total</u>
Current System	1218 ⁽¹⁾	6876 ⁽³⁾	0	8094
American Health Care Security Act	0 ⁽²⁾	0	6300 ⁽⁴⁾	6300

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NIMES data inflated to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 11.46 percent of payroll in a consumer products firm employing 500-999 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative estimate is that this percentage will not change.

⁽⁴⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent and income tax of 2.1 percent would raise the required amount of revenue.

COST TO THE EMPLOYER

Payments for Health
Insurance

Current System	6876 ⁽²⁾
American Health Care Security Act	6300 ⁽³⁾

⁽¹⁾ Assumes an average payroll in 1999 of \$60,000.

⁽²⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 11.46 percent of payroll in a consumer products firm employing 500-999 employees.

⁽³⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent.

SCENARIO 4

WORKER IN OWNER OPERATED GROCERY STORE

Demographics:

1	Age:	32
2	Gender:	Male
3	Family:	Married with one child
4	Health Status:	Child with chronic leukemia
5	Income:	\$60,000 in 1999, no other income
6	Health Habits:	Non smoker, non drinker

Current Health Insurance Coverage:

1	Benefits:	Medium Option: Basic coverage; \$500 deductible; no dental; Rx drugs Included; \$3000 out of pocket limit; 3 month waiting period for preexisting condition
2	Coverage:	Family: Major Risk Medical Insurance
3	Employer Payment:	Owner operator pays 100%

COST TO THE EMPLOYER

	<u>Out of Pocket</u>	<u>Premium</u>	<u>Taxes</u>	<u>Total</u>
Current System	6922 ⁽¹⁾	5394 ⁽²⁾	0	12316
American Health Care Security Act	0 ⁽²⁾	0	6300 ⁽⁴⁾	6300

⁽¹⁾ Estimates for out of pocket expenditures are based on computer runs of the NMES data inferred to reflect 1999 costs.

⁽²⁾ Assumes 100 percent coverage with 0 percent copayments.

⁽³⁾ According to the Employee Benefit Research Institute's calculations based on the 1992 supplement of the Current Population Survey and 1987 National Medical Expenditure Survey, employer health expenditures represented 8.39 percent of payroll in wholesale and retail trade firms with fewer than 10 employees. Because health insurance premiums are expected to increase faster than payroll, a very conservative assumption is that this percentage will not change.

⁽⁴⁾ Joint Committee on Taxation projects a payroll tax of 8.4 percent and income tax of 2.1 percent would raise the required amount of revenue.

Chairman STARK [presiding]. Thank you very much.

Before I recognize Lisa Priest, I did want to ask unanimous consent that the testimony of Drs. Hsiao and Dans, who, because of the weather, were unable to make it this morning, be included in the record, and I commend the testimony to my colleagues for their perusal.

[The prepared statements follow:]

Presentation Before the Subcommittee on Health
House Ways and Means Committee

February 9, 1994

by

William C. Hsiao

K.T. Li Professor of Economics
Harvard University School of Public Health

I am pleased to give an evaluation of a single-payer system. Simply put, a single-payer system can cut total U.S. personal health expenditures by at least 20% while improving quality and without rationing services. The cost reduction can be achieved without sacrificing access or quality because the U.S. now has a bloated and inefficient system. This 20% savings comes from three major sources. First, approximately 8% of the savings comes from reducing administrative expenses. Another 7% of savings can be produced by reducing unnecessary tests and surgeries. Finally, a savings of 5% will result from removing duplication and waste resulting from our excess hospital and laboratory facilities.

The U.S. has such an inefficient and expensive health care system for two reasons. First, we have freely chosen a wasteful approach by relying on a free market, private insurance system that naturally leads to multiple and complicated administrative systems and duplication of facilities. Second, the multiple insurer/payer system gives an "open checkbook" to physicians and hospitals. An open checkbook offers no incentive for providers to operate efficiently or balance costs with effectiveness in medical decisions. The fundamental debate in the U.S. is how to close the checkbook so that pressures will be put upon providers to remove waste and inefficiency.

An effective single-payer system has two essential components to control costs and assure quality. The first essential component consists of a global budget established prospectively for total health expenditures. A global budget serves as an effective fiscal cap over the health system which pressures providers to manage health care efficiently and adopt cost-effective medical technology. Without a global budget, everyone would want the latest glittering technology and newest drugs regardless of whether they would do the patient much good and regardless of cost. Second, under a single-payer plan, everyone is covered by public or private insurance plans so all payments to providers can be channeled through a single pipe. The single pipe payment enables us to effectively monitor quality and volume of services and control costs.

To operate our private insurance-based pluralistic free market system, the administrative costs amount to at least one-fifth of our health expenditures. My research found that the U.S. can cut approximately 8% of health costs by simplifying the administrative operations of a national health insurance program through a single-payer system. This estimate of 8% is quite consistent with those estimates prepared by GAO and CBO.

The second source of savings comes from reducing unnecessary surgeries and tests. Scientific studies show that between 20%-25% of the surgeries and high technology tests performed now are unnecessary. The New York Times' editorial on January 31, 1994, put it this way "Studies show that as much as one-third of current health care expenditure.....is for wasteful or ill-advised procedures."

A single-payer system would close the open checkbook by establishing a cap through negotiations on total health expenditures and uniform payment rates. More importantly, but often missed by analysts, the experiences of Rochester (N.Y.), Canada, Germany, and Japan show that a single-payer system would assemble the total practice profile of every physician. This

cannot be done under a multiple payer system. These complete practice profiles have been used effectively by other countries to monitor the practices of the aberrant physicians which may only comprise 10%-15% of the physician population. The other 85% of physicians were free to practice good medicine according to their best profession judgment, free from the intrusive daily monitoring conducted by the multitude of managed care plans as they operate in the U.S. now.

The monitoring of quality is usually delegated to the medical profession rather than the government or insurance plans. Other nations found that physicians were in the best position to monitor each other, not only because they have the expert knowledge, but also they can use professional persuasion, economic sanctions (such as refusing to refer patients to an aberrant physician), and social pressure to correct the medical practices of aberrant physicians. Unlike the market system where every third party payer has to set up vast administrative machinery, formal claims review processes, and cumbersome due-process procedures to enforce quality standards, a single-payer system sets the overall budget cap, establishes a uniform payment system, then lets providers compete on quality of services, monitored by the medical profession itself. Empirical evidence shows that a single-payer system not only is able to assure better quality of medical care, but at much less cost.

The third source of savings comes from reducing excess capacity. The United States has an excess supply of hospital beds and surgeons, and duplication of expensive laboratories. Our hospital beds are only using two-thirds of their capacity. We can reduce our health expenditures by at least 5% by removing the waste produced by excess supply.

What kind of single-payer system would the United States adopt? In my view, we should look toward Germany as a model. Germany realized that they could not remove their entrenched private non-profit insurance plans (i.e., sickness funds) from the scene once they were established. So they built a successful single-payer system where the federal government sets the broad policy guidelines but leaves the state to implement them, taking into account local conditions. German citizens continue to be insured by their sickness funds, but all claims are paid through a single pipe. Quality control and monitoring are exercised by the state medical associations. A global budget is established by negotiation where the payers -- representatives of sickness funds, employers, unions, and consumers -- sit on one side of the table while the representatives of the money receivers sit on the other side. The government stays out of the middle in setting the global budget so the process is not politicized with lobbying and political theater. Germany has been able to control its costs effectively at an affordable level and provide universal health insurance. There is no rationing in Germany and no waiting line. Of course, we do not have to adopt the German system wholesale -- we can improve it by introducing better quality assurance and modifying it to our own political and economic structure.

In summary, I would like to assess the single-payer system, using the six principles laid out by President Clinton in his national health security plan. The six principles are: security, savings, simplicity, quality, choice, and responsibility. On security, a single-payer plan is at least as comprehensive as the President's proposal. On simplicity, savings, choice, and quality, a single-payer system clearly is superior to the President's plan.

Anyone doubting that this can be done in the U.S. only needs to examine the experience of Rochester, N.Y. Its medical technology is first class and services are rendered without waiting periods. Meanwhile its medical costs are 34% lower than the U.S. average. Another success story is Maryland's single-payer hospital payment system.

Empirically, there is no doubt that a single-payer plan has proven to be a superior strategy. The question is whether we have the wisdom and political will to adopt it.

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Testimony of Dr. Peter E. Dans before the Subcommittee on Health Of the Ways and Means Committee of the House of Representatives-2/9/94

Mister Chairman, Distinguished Members and Honored Guests

Thank you for the privilege of being invited to testify on an issue about which I have felt passionately for over 20 years. I am not testifying today in my official capacity as a Deputy Editor of the Annals of Internal Medicine nor as a member of its parent organization, the American College of Physicians but as a private citizen who has had the opportunity to participate in and observe the medical care system from many different perspectives. Growing up in a cold water flat and then a housing project in New York city, I used free dispensaries and dental school clinics. In the late 40's when my mother was employed as a court interpreter, we were enrolled in the Health Insurance Plan (HIP), an early HMO. As a high school student in 1951, I debated the national debate topic: Resolved Should we adopt national health insurance?- an issue with roots at least as far back as the convening of the first national "Committee on the Costs of Medical Care" in 1927. That debate, shrill with accusations of "socialized medicine, was muted by the massive building of acute care hospitals through the HillBurton act as well as the use of tax incentives for employers to make medical insurance more affordable.

Still, when I graduated from medical school in 1961, people, especially the poor and the elderly, were being turned away from hospitals. Medicare and Medicaid corrected that but also institutionalized a usual and customary fee payment system that favored high-tech and acute hospital care over office-based care, long-term care and prevention. The lives of many were markedly improved by these reforms as I learned from caring for people in places as diverse as Massachusetts, Colorado, and Maryland. However, the incentives from these and other well-meaning reforms such as the expansion of medical school enrollment became perverse with the explosion in non-curative technology and the replacement of acute diseases by chronic ones as the population aged. By the mid-70's, when I was a health policy fellow in the U.S. Senate, it was clear that Medicare and Medicaid had fueled a health care cost crisis. However, most people were satisfied with their care and other issues like energy and defense took precedence.

In 1978, I returned to Johns Hopkins Hospital to establish one of the first medical practice evaluation units aimed at increasing the quality and decreasing the costs of care - now called outcomes research and continuous quality improvement. I watched the cost crisis worsen as AIDS, drug and alcohol abuse, violence, tuberculosis, and homelessness overwhelmed an eroding public health system. Unfortunately, the medical care system's

after-the-fact response was tremendously expensive and only marginally effective. For example, drug-addicted patients coming to the Emergency room to kick the habit would be given a number to call for programs whose waiting lists were months long. However, if they had infected their heart valve with a dirty needle, we could admit them for a valve replacement at great expense.

So why is there so much controversy about whether there is a "crisis"? I believe it is because of imprecisely diagnosing it as a "health care crisis". Health care, or what is more appropriately called medical care, is not in crisis. While it needs improvement in its distribution, organization, and (in some areas) its quality, our medical care is generally acknowledged to be very often the best in the world. We do, however, have a crisis in what medical care we pay for, how much we pay for it, and how that payment is administered. As a result, we have a coverage crisis whereby too many Americans do not have basic medical care benefits.

I am here today because I believe Congressmen McDermott, Stark, and their cosponsors have made the right diagnoses and have tailored their treatments accordingly. They don't rely on untried concepts not found in nature like health insurance purchasing cooperatives which threaten to interpose large impersonal bureaucratic organizations between patients and their doctors. Instead, they propose to take a payment system that has worked in Germany, Canada, and other developed countries and tailor it to fit America. Even in America, in my home state of Maryland, an all-payor system for hospital care has worked extremely well in holding down costs while not adversely affecting care.

By mandating a basic medical benefits package and developing a uniform system for paying for it, the bill will take much of the confusion out of the current system. It also will reduce the huge administrative costs which do not translate into improved care but instead enormously increase the hassle factor for patients, their families and for physicians. I have seen this from both sides. My parents died in 1991, six months apart. I had to cope not only with my grief, but with masses of fragmented and almost unintelligible medical bills. I had to communicate with 3 separate insurers, of whom only Medicare seemed readily willing to fulfill its contractual obligation. Having a medical degree was of little help. As a physician, I have also seen the harassment by multiple third party payors with a myriad of conflicting rules. Rather than improve quality, these rules have fostered the creation of a paperwork bureaucracy and at times have even restricted care.

Another reason I favor this bill is that it doesn't incorporate the other untried concept we so often hear about, "managed competition". We don't need more competition in the medical care system. Competition is largely to blame for the combination of maldistribution and duplication of services. We need more collaboration for the same reason we don't have competing

fire departments in a given jurisdiction. During war, we don't contract out medical care services to competing groups; we integrate them beginning with triage at the front all the way back to the stateside hospitals. Indeed, under the threat of legislation, we are already seeing unprecedented mergers among institutions in Boston and Philadelphia that once competed for the same pool of insured patients. We have seen collaboration work effectively to improve care and hold down costs in Rochester, New York. By removing many perverse payment incentives, this bill will level the playing field in medical service areas. Global budgeting will encourage states and regions to convene all local interested parties to define the needs of their inhabitants and then to make sure that the quality, mix and distribution of services meet those needs.

To help the local entities concerned with quality of care to accomplish these goals, the bill mandates the development of a national electronic database for patient records. Such systems are becoming more widely used in such countries as The Netherlands. This will improve care by making key clinical information portable in our highly mobile society. It will also permit the analysis of patient outcomes and comprehensive profiling of institutions and physicians rather than insurance plans. From almost two decades of experience, I can attest to the general inadequacy of most claims data for accomplishing these tasks. I see physician profiling not as a "report card" with grades from A to F, but primarily as an educational tool. The vast majority of doctors want to know how they are doing and how to do better. It can also serve to identify the small percentage of "bad apples".

The bill also encourages the recognition of centers of excellence within medical service areas. As someone who helped establish a migrant health center in Fort Lupton, Colorado-now a thriving one-class community health center, I am pleased that the bill takes into account the special needs of the medically-underserved. Competition hasn't worked very well in rural areas and inner cities-not just for medical services but also for other necessary services.

The bill is silent on two important issues. The first is malpractice reform. However, I agree with the sponsors that this issue should be tackled separately. I believe that tort reform should be across the board. A society where someone who is drunk and falls off a subway platform can win millions of dollars in awards is completely out of whack. A system which seeks "deep pockets" to blame rather than trying to rectify any errors, most of which are unintentional, is ripe for reform. Compensating those who should be, many of whom are not compensated under the current system, in a non-punitive way would take the onus off the majority of physicians and lead to improved care. Rather than continue the disabling specter of litigation for the good doctors, I would prefer that we isolate the truly negligent physicians and deal with them punitively.

I also urge that Medicine be exempted from the provisions of the Anti-trust act, as it was before a 1970's ruling. Medicine is a profession not a trade and doctors ought to be expected to act accordingly. If baseball can be exempt, it's not clear why Medicine should not be. My concerns stem from my term on Maryland's Board of Physician Quality Assurance from 1988 to 1992. Although almost a quarter of the complaints involved allegations of excessive fees, virtually all were dismissed, even though one of our standards prohibited "gross and wilful overcharging". Presumably, because doctors couldn't know one another's fees, we could not prove that even the most outlandish fees were gross, let alone wilful. The medical society also refused to get involved as a mediator, as it had in previous years allegedly because it had been sued once for restraint of trade. For the same reason, doctors who were aware of the "bad actors" cited the famous 'Patrick case' which hinged on concerns about 'restraint of trade' as a reason for their reluctance to come forward. The potential for individual harm simply outweighed the benefit. In a new era stressing professionalism and cooperation for the public good, treating Medicine as a trade is out of step.

I would also favor reinstating the ban on advertising. Advertising drains resources from the patient and invites overstatement and downplaying problems. It makes us "spin doctors" not medical doctors. Even at Johns Hopkins, justifiably recognized as one of the premier hospitals, the premise of our office of medical practice evaluation was that as good as we were, we could be even better. Again, no surprise here, because medical care is a complex social enterprise involving imperfect people working in an imperfect system. The idea should be to strive for perfection by identifying errors and correcting them, not hiding them.

Finally, I am very much concerned that the terms of this debate were established by a secretly-convened task force whose plan was being sold even before it was made public. Some of the press coverage suggests an "enough already" attitude with the issue being reduced to a two horse race with the handicappers urging you to get your bets down. This issue is simply too important to come to premature closure. I have also been dismayed at the polarization created by the tendency to cast villains as well as to substitute slogans, jargon and catchy phrases for clear and reasoned analysis. In the process, the "Cooper" bill becomes "Clinton Lite". The single-payor proposal is dismissed as not politically viable and too "liberal" when as a matter of fact, it is probably the most fiscally conservative and least intrusive into the patient-doctor relationship.

It gets to the root of the most pressing problems and preserves the best of the current system. It does so in 200 pages as compared with anywhere from 600 pages to 1364 in the competing bills. There's an enormous risk for mischief in those extra 1000 or so pages. As a health policy fellow, I saw too many well meaning ideas start simply and then run

amok as micromanagement mania and a lack of trust led to the orchestration of every last detail. As a result, the law-abiding people got tied up in the red tape of voluminous regulations while the operators figured out how to get around them. Whatever you do I urge that you keep it as simple and as surgically precise as possible. This isn't about getting it done but getting it right. What you do will have profound effects on the the profession of medicine as well as how Americans choose to live and die. Thank you for your attention.

Mr. McDERMOTT. Mr. Chairman, may I say that the last page of Dr. Hsiao's testimony, beginning with "in summary," I think is probably the best, most concise compilation of what he has to say, and he essentially, unfortunately, was snowed in in Boston. I would love to have him here saying it.

Chairman STARK. So he could not snow the rest of us this morning [laughing]; is that right?

Mr. McDERMOTT. No. He would tell us the truth actually.

Chairman STARK. Having said that, I would like to recognize Ms. Lisa Priest, a journalist from the Toronto Star.

Please proceed, Ms. Priest.

**STATEMENT OF LISA PRIEST, HEALTH POLICY REPORTER,
TORONTO STAR, TORONTO, CANADA**

Ms. PRIEST. Dear Mr. Chairman and members of the committee, I am a health policy reporter for Canada's largest newspaper, the Toronto Star, and my only agenda as a journalist is to relate as dispassionately and as objectively as I know how some of the strengths and weaknesses of Canada's \$67 billion health care system.

In a country divided by language, various cultures, and frequent constitutional squabbles, health care has been the one thing that united and defines Canadians. Indeed, many would feel un-Canadian without its health care system and its principles of universality, comprehensiveness, accessibility, portability, and public administration.

Canadians are overall very satisfied with their health care system. Recent surveys show 84 percent of Canadians rate the quality of their medical services as excellent, very good, or good; 81 percent think government should pay for health care of all Canadians, regardless of their income.

Saying that, we are having some problems with financing, and the Federal and Provincial governments are trying to determine what we can no longer afford.

Sixty percent of Canadians approve the charging of user fees, and 82 percent believe that the government will introduce them sometime in the future.

One of the problems that you have with capped resources inevitably is that you are going to get waiting lists, and much of my reporting has concentrated on waiting lists. And since this is a public system, you tend to find out about them quite a lot. And I would like to give a few examples.

One of them is that Sunnybrook Hospital, you have to wait up to 9 months for a hernia repair, 8 months for gallbladder surgery. If you are a routine patient wanting a crack at the magnetic resonance imager, it is 9 months. At Toronto Hospital, it is 4 to 9 months for an autologous bone marrow transplants, which is deemed as urgent care. Essentially anyone who needs emergency care gets emergency care.

And these problems, for the most part, are reflective more of poor management than resources. In the past, we have always chucked money into the system, and our budgets were growing at 10 percent a year, and then we found that essentially we were not man-

aging the resources well, and a lot of these things can be fixed with central registries.

Cancer, we have had a real problem with cancer care. I remember interviewing a woman who had to be driven by her paraplegic son up to northern Ontario for radiation treatment. But overall, Canadians do get access to their health care.

And I have also covered good stories where I have seen two brothers with cystic fibrosis get double lung transplants, and that was a total cost of \$300,000, and they did not even know how much it cost.

The Canadian health care system, though, is not in crisis, which a lot of people tend to think, but there are just certain things that need to be fixed.

And what is happening right now is that they are delisting certain procedures. A lot of these procedures, Canadians think, are cosmetic anyway. They are things like tatoo removal and acne removal and sterilization reversal. Those things are being delisted, 20 million dollars' worth in Ontario right now.

As well, doctors are not part of a socialist medicine state. In fact, 90 percent of the country's 60,000 physicians are self-employed, fee-for-service practitioners who bill the Provincial health plans for each medical procedure they perform. In fact, they are also able to bill on top of that for third-party billings such as doctor's notes and aviation medicals and things of that nature.

Since there is little utilization management on prior approvals, physicians enjoy really a free way of practicing medicine. They do not have insurance companies calling them us saying: Here, how about that patient and hospital; when can you get them out? They really practice on the Lone Ranger model for the most part, and they negotiate their payments with government, so government gets a very good bargain for the doctors.

Right now in Ontario, doctors are at a cap, and they are paid—the 22,000 physicians are paid \$3.9 billion a year. If they bill anything over that with this hard cap, they have to pay back the money to government, and, in fact, that is what they are doing right now. They anticipate that they will run out of this \$3.841 billion by mid-March, and the Ontario Medical Association has, in fact, told its doctors: Could you please take a week off in March sometime and not see any more patients, so we keep our utilization down? And they are going to end up holding up on \$148.9 million. And the government gets that money by a clawback; essentially they dock their pay.

Hospitals are also downsizing. Over the past 5 years, they have taken out 5,000 beds in Ontario alone, and still they are seeing a lot more patients than before because of the move to day surgery.

And I would like to end this by—I did notice that someone had mentioned that a lot of Canadians go down south. We do have a big fraud problem. Of our \$17.5 billion budget in Ontario, up to \$700 million is fraud, some of it from Americans coming to Canada to get care. And they are trying to control that, and they are having a devil of a time.

And as a journalist, I would just like to finish by saying that I am always trying to look out for the health care system.

Chairman STARK. That is because they are so mad that we make all those Fords and Chevrolets up in Canada. Just trying to get even. [Laughter.]

Ms. PRIEST. I would just like to end by saying that I have tried to look at health care systems in other countries to see what should Canada be doing, what should we emulate, and for the most part I think Canada is a very good system, and it is just that you hear about the bad things because of the public accountability aspect, but over all it is quite a good system going through changes.

[The prepared statement follows:]

**STATEMENT OF LISA PRIEST,
HEALTH POLICY REPORTER, TORONTO STAR**

Dear Mr. Chairman and members of the committee:

My name is Lisa Priest. I am a health policy reporter for Canada's largest newspaper The Toronto Star, an invited witness of the subcommittee on health and a patient in my country's health care system.

As a journalist, I will endeavour to relay - as dispassionately and objectively as I know how - some of the strengths and weaknesses of Canada's \$67 billion health care system.

In a country divided by language, various cultures and frequent constitutional squabbles, health care has been the one thing that unites and defines Canadians. Indeed, many would feel un-Canadian without its health care system and its principles of universality, comprehensiveness, accessibility, portability and public administration.

While Canadians are very satisfied with their health care system, they are concerned about the profound changes taking place as federal and provincial governments determine what we can no longer afford.

I would like to put a human face on our health care system as seen through the eyes of patients, doctors, government officials, hospital administrators and many others who have been involved in the emotional debates during this transition period.

Here are just a few recent snapshots:

- Two brothers with cystic fibrosis each received double-lung transplants. When they left Toronto Hospital a few months ago with their new, pink lungs they didn't have to worry about the tens of thousands of dollars it cost. In another health care system, they could have perished.

- A woman in her 60s, stricken with breast cancer, had to rely on her paraplegic son to drive her hundreds of miles to Northern Ontario for radiation treatment, following her surgery. A backlog in radiation spots meant she couldn't obtain treatment at a hospital near her home in Metropolitan Toronto. But she didn't mind travelling to Sudbury at her own expense.

- In Toronto, a dialysis patient said she was literally waiting for someone to die or get a kidney transplant so she could take over someone else's spot. Dialysis is in great demand as the number of patients increases disproportionately to resources. (Dialysis patients are increasing annually by 10 per cent in Toronto.)

- When I was 13 and a pedestrian, I was hit by a car. Near death, I was rushed to hospital with broken bones and other injuries. As I lay in emergency and later in the intensive care ward, all my parents had to worry about was whether I would recover. They never had to fret about how much it would cost and it's a good thing - because they could not have afforded my hospital stay and subsequent rehabilitation. Like most Canadians, I have no idea of how much my medical care cost but I am thankful to the doctors who saved my life and a system that has no financial barriers.

Inevitably, a system with capped resources will have the rather undesirable consequence of waiting lists. While there are no waiting lists for emergency care, there are many for so-called "elective" procedures, including those for hip replacements, cataract surgery, knee replacements, appointments with some specialists, to name just a few. However, the word elective is a misnomer as these are not optional medical procedures - patients do need them.

Currently, routine patients wanting a crack at the medical world's hottest new diagnostic tool, the Magnetic Resonance Imager, have to wait up to nine months in some areas, whereas urgent patients wait less than a month. In the province of Alberta, a private MRI clinic has opened up and patients wanting the diagnostic procedure quickly can get it - for a price.

Many health care critics believe that Canada's waiting lists reflect poor resource management and planning in addition to a lack of funding. For example, in the late 1980s, there was a cardiovascular surgery scare. Countless stories detailed how patients needing heart surgery were dying waiting for treatment. Indeed, some Canadian patients flew to the United States for surgery. Some critics screamed there weren't enough doctors. Others complained there were too few operating rooms. A small amount of money and the creation of a central registry that prioritizes patients according to need solved this problem quickly and quietly.

Short waiting lists, as some health policy analysts point out, are desirable as it means the most efficient use of resources. As one physician told me, "there's nothing more dangerous than an idle surgeon." In fact, an open-ended system with unlimited resources would likely result in more surgery and treatment than is medically desirable. And it has been pointed out that there are no scientific studies to prove waiting lists hurt patient outcomes.

However, I have interviewed many people on waiting lists and observed their anxiety and intense psychological pain waiting for treatment. Some of them wonder whether they will get help in time. Since those in need of emergency and urgent care don't have to wait, other patients frequently get their dates of operations changed. It is not unusual for a patient to get psychologically prepared for open heart surgery or another serious procedure only to be told he or she will have to wait another month. Others are in so much pain they can't work, costing the system more in lost wages and taxable income. While waiting lists may make good economic sense, they are often at odds with a patient's quality of life.

For example, a man named Alan Boothe is on an 11-month waiting list for a right partial knee replacement. At times, the pain of bone rubbing against bone is so severe it wakes him at night. The way he talked about his upcoming operation this fall reminded me of a child counting down the days until Christmas.

At Canada's largest acute-care hospital, The Toronto Hospital, it takes four to nine months to get an autologous bone marrow transplant. At that same hospital, it currently takes about one month to get surgery for head and neck cancer - which as you probably know - produces a tumor that doubles in size within 60 days. This hospital isn't much different from the hundreds of others across Canada. One Canadian radiation oncologist said if he was diagnosed with head and neck cancer today, he'd "panic like hell and go to Buffalo."

Americans hearing these stories would find this kind of waiting intolerable in the same way many Canadians find the U.S. system - which leaves 37 million people without health insurance - impossible to fathom.

But there is no perfect system. Canadians are justifiably proud of their health care system yet recognize there are areas that need to be fixed.

One constant source of worry is the decreased funding from the federal government. Having lured the provinces into Medicare three decades ago, the federal government started becoming alarmed at rising costs and has been steadily decreasing its funding to the provinces. The 50/50 federal and provincial government split in health care spending three decades ago has now decreased to 30/70. Provincial governments are also concerned about increased costs and have been in the process of de-insuring or de-listing some medical procedures.

For example, In Ontario, the provincial government and its doctors are in the midst of slashing \$20 million worth of medical procedures which are presently covered under the Ontario Health Insurance Plan. Some of these proposed cuts include tattoo removal, in-vitro fertilization, sterilization reversal, routine circumcision, and annual health exams.

An Environics Research Poll done on behalf of my employer, The Toronto Star, revealed an overwhelming majority of people believe that cosmetic procedures such as acne and tattoo removal should not be covered under the health plan. Interestingly, a majority of those polled last month also support middle- and upper-income seniors pay part of the cost of their drugs, which are currently covered by government.

Doctors, too, are waged in battles with their provincial governments. More than 90 per cent of the country's 60,000 physicians are self-employed, fee-for-service practitioners who bill the provincial health plans for each medical procedure they perform. Doctors are also able to bill separately on a fee schedule for non-essential procedures, which are largely cosmetic. Since there is relatively little utilization management or prior approvals, physicians enjoy a rather free way of practicing medicine. They do, however, negotiate their payments with government and many physicians - who prefer to practice on the Lone Ranger model - don't like any affiliation with government.

The Ontario government likes to label its negotiations with the province's physicians as lively. Recently, the Ontario Medical Association, which represents 22,000 physicians, agreed to a hard cap which means they have to pay the government anything they bill over a \$3.9 billion annual ceiling. This year, they have gone over their cap and are in the midst of paying the government a projected \$145 million. They do it grudgingly as many doctors believe they shouldn't have to pay back what they have earned while caring for their patients.

This payback is done through a clawback, which means each physician's pay is essentially docked. Two weeks ago, the Ontario Medical Association sent a notice to its physicians, asking them to take one week off in March in an attempt to keep health care costs down. Despite some physician complaints, Canada has a good track record for keeping its doctors. In Ontario, for example, about 100 physicians move to the United States each year, which amounts to less than half a per cent. Within five years, half of those physicians have returned.

Canadian hospitals are also going through a period of restructuring and downsizing. In Vancouver, a hospital was recently closed. Ontario's 222 hospitals are in the midst of slashing \$260 million from their budgets under the Social Contract Act, which was imposed by a provincial government that needed to cut \$2 billion from its deficit. This is in addition to the millions of cuts they have already made and the 5,200 beds that have closed over the past five years in Ontario. In Toronto, a nine-member committee is being formed by the Metropolitan District Health Council, a government advisory body that plans health services in Metro Toronto, to realign 44 hospitals. It could mean the closing of some hospitals and the program mergers of others. Already, hospital presidents are busily meeting and trying to merge programs in an effort to make changes before the committee does it for them.

Perhaps the most pronounced part of Canada's health care system is how politicized it has become. Patients routinely call journalists to tell them their health care woes. Writing or broadcasting a story, patients think, will get them better access to treatment. Often, they're right. A news item that exposes a serious flaw in the system means it will be picked up by other media and opposition political parties will raise it with government in the legislature. In fact, I've seen health policy made in this fashion.

Months ago, news broke on how two big Toronto teaching hospitals had hired a marketing manager to help them sell medical services to the U.S. Americans could order a la carte from menu at a cost less than the U.S. but more expensive than what is charged in Canada. When this news broke, it hit a nerve. Canadians were outraged and they let their elected officials know they did not want their health care sold to anyone. Critics said it would create a two-tiered health care system - the bottom tier for Canadians and a second one for rich Americans. Even more said Canada should get its own house in order before it starts selling health care elsewhere. Within days, the plan was dead. Ontario Health Minister Ruth Grier declared that the province's \$17.5 billion annual health care system was not for sale.

The crisis in cancer treatment is another example. Patients have been receiving mutilating surgery because they couldn't get timely access to radiation therapy. Voiceboxes were being surgically removed and women were getting mutilating mastectomies because the waiting lists for radiation treatment had doubled in the past decade. Other patients became incurable waiting for treatment. Dying patients - who needed radiation for comfort during their last months at life - were being drugged instead because their chances of getting on the waiting list were worst of all. At a recent task force hearing, radiation oncologists and hospital presidents stated at least 13 per cent of patients who could benefit from radiation weren't receiving it.

Each day, opposition Liberal and Conservative leaders lambasted Ontario's provincial New Democrat government for weeks in the legislature, complete with horror stories from their constituents. This problem - predicted two decades ago - was finally getting the profile it deserved only because of public pressure.

Shortly after, the Ontario government approved a \$1 million annual plan to hire 20 more much-needed radiation therapists. As well, it approved the hiring of more radiation oncologists and officials vowed to form a long-term plan for cancer treatment. Soonafter, the Liberal party formed a task force on cancer care, travelling the province to hear stories from hospital staff and patients about the quality of treatment. I point to this example because it so clearly illustrates that political pressure and will are often the sure way to get a problem in our health care system fixed. While this is a terrific method of accountability, it seems an odd way to make public policy. Without question period, the opposition political parties and the media, some horrors in health care could go undetected and uncorrected.

Health care is moving in new directions in Canada. Hospitals are downsizing but aren't nearly as far as the United States. If Canada could achieve the same efficient use of hospital beds as the U.S., 30 to 40 per cent of our beds could be closed. Those resources could go to day surgery, outpatient and community care.

However, other gains are being made. Physicians are stressing preventive care and policy makers are preaching the determinants of health. Governments are becoming more involved with public policy such as tough tobacco and seat-belt legislation. Patients are finding out that health care isn't "free." In fact, government ads are informing them that they don't need to go to the doctor for a cold, which has cost the health care systems hundreds of millions of dollars. Centres such as the Institute for Clinical and Evaluative Sciences in Ontario and Manitoba's Centre for Health Policy are measuring the cost-effectiveness of certain procedures. One study found that \$4.26 million in health care could be saved each year in Ontario if vasectomies were done in doctors' offices instead of hospitals.

Canada's health care system is facing many challenges. Hospital administrators, government officials and health care providers are trying to meet that challenge by doing more day surgery, stressing preventive care, community care and adopting other methods of containing costs while treating the country's 27 million residents.

As a journalist who likes to compare health care systems in other countries, I have often looked abroad to see if there's a place Canada should model itself after. But every time I look elsewhere, I always come back to my country. It's true, we do have to wait for some of our health care and we don't always like to. But we figure a little waiting for all of us is better than letting others go without care.

Chairman STARK. Thank you, Ms. Priest.

If I could, there is a rather bizarre notion that you could have a huge single publicly-financed plan without some politics getting involved in it.

Could you kind of just summarize? Your Parliament, I mean, are they really second-guessing the doctors and the system, or do they only come in in an oversight capacity and on occasion to try and fix the system? I mean, how involved is your Parliament in the day-to-day running of the system and managing it?

Ms. PRIEST. Actually the Ontario Government and the Ontario Medical Association just formed what they called a Joint Management Committee. It was formed 1½ years ago. And what they also did is, they set up an Institute for Clinical Evaluative Sciences, which does a lot of—measures the cost-efficiencies of certain procedures, variations across the Province.

Chairman STARK. Who participates in these boards or organizations?

Ms. PRIEST. The Health Minister and Deputy Health Minister would be on the Joint Management Committee, and members, senior members, of the Ontario Medical Association, which is sort of—they do not like to call it this, but it is sort of a union of doctors, and they decide jointly on future health care practices.

Chairman STARK. OK. Dr. Anderson, you gave us some examples of how the world would fare under the McDermott bill. Have you made similar calculations about other proposals, such as the Stark bill or the Clinton bill or the Thomas bill?

Mr. ANDERSON. I did, while I was listening to Mr. McDermott, some calculations on the President's bill, and effectively what I showed was for families of four in 1999 earning \$20,000, \$50,000, and \$100,000, they would pay less under the McDermott bill than they would under the President's bill.

Chairman STARK. How about under Mr. Thomas' bill?

Mr. ANDERSON. I have not had an opportunity.

Chairman STARK. I wonder, it would be interesting—I was reviewing your figures—if you would care to, as we go along and a couple of alternatives become more clearly identified—I am not sure now that there are an awful lot of bills out there with names on them that are not quite as clearly identified as Mr. McDermott's, but I would appreciate it—I am sure my colleagues would find it interesting if you would, at some point, maybe in the next couple of weeks, extend your research and see how it compares with other programs, the Cooper bill, for example.

Mr. ANDERSON. I would be glad to do that. What I insisted with Mr. McDermott, however, is that the CBO go first, effectively, because I do not want to go out there and be essentially making my estimates and then having somebody else do another estimate. So I would be very happy to do it after CBO has done their work.

Chairman STARK. OK. Thank you very much.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I just hope CBO moves forward after their brief respite that they were so desperate for. Give them the weekend. I wonder if they showed up today on a slow day.

I echo the chairman's desire for some kind of an ongoing analysis. We are inevitably required to compare apples and oranges, and to the degree we can compare apples and apples and look at the upsides and the downsides, it makes our job not easier, but at least slightly better at doing something that works. And I think that is the fundamental motivation of most of us.

Ms. Priest, you are a reporter, and you responded to the chairman's question in regard to the Provincial and National Legislatures in the political battle of what we can afford, and they have set up a structure to assist them in making that decision.

You said something else that I am wondering if you had any stories about or anecdotal information about, and that was that for particular elective surgery, there appears to be inordinate or perhaps unacceptable waiting periods to get that, but for emergency care, it seems that you can jump the queue and go right to the front.

Do you have any instances of folks gaming the system or doctors attempting to define something as an emergency care rather than elective to try to jump the queue to get patients some kind of service prior to what they would ordinarily if they played the ballgame the way it is supposed to be played.

Ms. PRIEST. There is always—I have heard some people and senior administrators in hospitals say: You know, it is only human nature that if you are sort of well-known or if you have connections, you will jump the queue. I have not seen one particular person that has done that, but I have heard anecdotal stories that if you know people and that doctors generally like tend to like to take care of people who are more like them and educated and more well off. So there have been instances.

Mr. THOMAS. So to a certain extent, you are saying that, as it is kind of in politics, it is not what you know; it is who you know in a system that is controlled from the top down.

Ms. PRIEST. In a way. I mean, that is not representative of the system. It is probably a very small amount of the cases.

The problem we have with waiting lists is that we do not have waiting lists. There is no list in an office that says: Hey, here is your name, and this is where I call.

Mr. THOMAS. Take a number and wait, yes.

Ms. PRIEST. It is a laundry list in someone's head. And that is the real problem, and that is when you can get the queue-jumping.

Mr. THOMAS. Dr. Anderson, you wanted to say something?

Mr. ANDERSON. Yes. I have a grant from the Federal Government looking at queuing right now in Canada in the Province of Manitoba specifically related to cataract surgery. And what we see is, if somebody has a serious problem because they cannot drive or something like that, each doctor has their own waiting list, but every once in a while somebody cannot have surgery for a particular reason, and that person becomes the person who gets put into the queue and gets care very quickly. So doctors have their own internal ability to prioritize. And that is pretty much what they are doing in Manitoba.

Mr. THOMAS. Prioritize between doctors of the same specialty or within a doctor who has his own list and can bump his own list?

Mr. ANDERSON. His own list.

Mr. THOMAS. His own list.

Mr. ANDERSON. Correct.

Mr. THOMAS. OK. Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman.

I want to talk a minute about this situation and ask Ms. Priest a couple of questions.

The illustration used in the Northwest about why the Canadian system is so much of a problem is that the British Columbia Government said there was this long waiting list for heart surgery. So they wrote a contract with the State of Washington and the University Hospital for 200 cases.

And I have examined every anecdotal thing anybody says about Canada, and I go and try to find out if it is true or not. So I went to them to figure out what had happened.

First of all, it took more than a year for them to find 200 cases to send down to the United States. So there was no great waiting list. We have unused capacity at the University of Washington Hospital that I tried to stop, but they could not find any Canadians to send down there.

Then it turned out that what really was the problem in Vancouver is that there are two very famous heart surgeons. Everybody wants to be done by those two people. The other 8 or 10 very competent surgeons did not have any waiting list, but two people had long waiting lists.

And my experience really jibes with what Dr. Anderson found in cataracts in Manitoba.

I want to ask a question of Ms. Priest, though. There is now a rumor around in the Congress that Canadians are shutting down hospitals. And when the people were down from Ontario, the woman who is the president of the Canadian Hospital Association and the head of the Ottawa General Hospital were in my office, they said: The next thing you are going to hear from Canada is that we closed hospitals. And she said: The fact is that in the old days when there were no paved roads and no snowplows, we put a hospital about every 20 miles, and we have got these hospitals all over the place, and they are so inefficient, we are now closing them.

Is that a fair representation of what the hospital-closing rumor out of Canada is all about?

Ms. PRIEST. That is exactly right. On University Avenue in downtown Toronto, we have six or seven hospitals within about two blocks of each other. And we just built too many hospitals, and now we are in the process—no one has really had the guts to actually close them down, so they are taking the beds out of the system. But there is a District Health Council in Toronto that is spending the next 18 months looking at reconfiguring the hospitals and possibly closing some.

But also four hospitals on University Avenue have formed a—are in the midst of forming a consortium, so that all the duplication with human resources and microbiology labs, that will be gone, and they will save, they figure, tens of millions of dollars by doing that.

So whenever people scream that hospitals are closing, they really need to. There are just too many, and we do not need that money.

Mr. McDERMOTT. Have you done any research about the actual number of Canadians whose health care is in the United States?

The numbers that I got from the Ontario Government in the past were that about 4 percent of their budget was spent in the United States. Half of it was by snowbirds, older people who had come down to the United States, got sick here and had their health care in Florida or Arizona or California, and the other 2 percent was for a variety of reasons and people.

Does that square with the kind of figures that you have seen?

Ms. PRIEST. I am not really familiar with the figures. But I do know from what I understand that it is a very small amount, that most people get their health care in Canada. And you are absolutely right; it is when you are out of town that you are getting it, if you are old and you are away in Florida. Then, you know, you are going to get your health care there.

And I think for a brief period, there was a time where our head injury people were going down to Texas.

But those are the only instances I have heard of where people have gone south. Most people are, you know, afraid to come down south from Canada. Their two big fears are getting shot or getting sick.

Mr. McDERMOTT. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. McCRERY. Ms. Priest, is it your impression from your work in journalism that the health care system in Canada is improving, or do you see any patterns of decline in the health care system?

Ms. PRIEST. One big area of decline is the Federal funding that is funneled down to the Provinces before health care spending would be split 50-50 between the Provincial governments and the Federal Government.

Over the past few years, actually the past 10 years, they have been—it has split now to 30 percent Federal funding, and they have passed it on to the Provinces, which in turn cannot afford quite a few things, so they are, in turn, delisting.

So that is one big area where, you know, we are getting less money.

Mr. McCRERY. So as a result, you are seeing, I suppose, differences in the quality of health care among the Provinces?

Ms. PRIEST. We do not have a homogeneous care package across the country. I think that is one problem, is that like four Provinces fund psychoanalysis; other ones do not. Some do in vitro fertilizations; other ones do not. But the Federal Health Minister is trying to get it so that we have a homogenous package instead of the 10 little health care systems across the country.

But that has been what is happening. Since it has been shoved onto the Provinces, they have been delisting and cutting without any kind of comprehensive line across the country.

Mr. McCRERY. How do you pay for your health care system in Canada? Is there a separate tax for that?

Ms. PRIEST. You know, I have no idea how much I pay for my health care system. It is just taken off my taxes. The Ontario Government, for instance, a third of their budget is health care. That

is \$17.5 billion a year. But I do not know the precise figures per person. It is just taken off our taxes.

Mr. MCCRERY. So you do not know if there is a separate health care tax in Canada, or if it just comes out of general revenues?

Ms. PRIEST. Oh, I am sorry. It does come out of general revenues. That is right.

Mr. MCCRERY. So there is no separate health care tax?

Ms. PRIEST. No, no.

Mr. MCCRERY. What problem do you hear most frequently voiced from people that you encounter while you are studying the Canadian health care system?

Ms. PRIEST. I think the worst one was the radiation backlog, which they are trying to fix right now. There are people literally getting their throats ripped out, their breasts chopped off. They were getting mutilating surgery because they could not get radiation treatment. With larynx, head and neck cancer, for instance, the radiation would have been able to shrink the tumor, but instead, since they had to wait in the queue so long, it had grown big; it had maybe become incurable, or it had to be surgically removed.

So we had people losing their voices when they did not need to lose their voices. We had women losing their breasts when they could have had a lumpectomy and radiation.

At one point, the radiation backlog was 14 weeks, and this is treatment that you are supposed to get ideally within 1 month. I mean, that is a clinical standard. That is one big area.

We also have problems with any kind of orthopedic surgery, hip and knee replacements and bone marrow transplants, which actually is urgent care. But we have waiting lists for that.

Mr. MCCRERY. Well, has the Federal Government in Canada addressed these problems?

Ms. PRIEST. It is usually the Province that will do it, and what happens is that somebody screams about it and brings it up in a legislature, and then the opposition will go after the government, and they usually try to do something about it.

Right now, they have poured \$1 million into hiring more radiation therapists, and they are trying to come in with a long-term plan as well. The problem with oncology is really a worldwide one. There is a shortage of radiation oncologists, and I know that they are trying to recruit some from around the world right now. So they are addressing it, and the queues are getting smaller, but they are still there.

Mr. MCCRERY. So has your experience been that the government, whether it is the Provincial government or the Federal Government, then responding in a timely way to the problems that have cropped up in the health care system, or does it take a long time for the political system to react, or what is your experience?

Ms. PRIEST. It has to be political, because these problems, especially for radiation, were predicted, and I think the first time was 1973 or 1975. I mentioned these were old, old problems, and people are looking at how we are treating more people with radiation and how we are having an aging population. So there were reports after reports after reports done, and nobody did anything until someone

started screaming about it. And that is usually what it takes. It does not always fix itself on its own.

Mr. MCCRERY. So essentially what you are telling us is that when there is an identified problem in the health care system concerning a lack of facilities, a lack of services available to treat people in a Province, it is the political system that has to respond, and your experience has been that the political system takes a long time in some cases to respond?

Ms. PRIEST. In that particular case, it did. I mean, once it was brought out into the public eye, it was solved quite quickly. But in some instances—and there are other cases where doctors sometimes are able to solve it, but mostly you need a big, massive restructuring to form central registries or funding. Those are usually the answers.

Mr. MCCRERY. Thank you.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Yes. Mr. Chairman, let me just say something about Dr. Hsiao and Dr. Dans' testimony. Dr. Hsiao if he were here, would testify that the single-payer system would cut 20 percent from national health care expenditures without affecting cost or quality. That is his testimony.

Dr. Dans would testify that the single payer is the least disruptive of all of the proposals and the most conservative in terms of experimental changes. And this is a doctor talking from the Annals of Internal Medicine. He is an internist from the American College of Physicians. So as doctors look at it, it is the least disruptive.

And I want to ask a question of you, Dr. Anderson. There is some conventional wisdom here on Capitol Hill that price controls will not work. Could you expand on your testimony regarding why you think they will work?

Mr. ANDERSON. Well, I think we have to look at the fact that they have worked in places like Maryland and other places as well. They have been able to control the rate of increase in health care spending. They have been able to do that without any demonstrated adverse effect on quality. The studies have shown that access to care, especially to the uninsured, have been improved.

The hospitals themselves have been able to acquire capital, to acquire new technology, and they have been able to do this in essentially a globally budgeted system.

In Maryland, we have been working for the last 18 years under a global budget set by the Medicare program. And as Mr. Cardin and others have suggested, the health care system in terms of quality of care in Maryland is equal, if not better, than any place in the country.

Mr. MCDERMOTT. I think Congressman Cardin created that system.

Mr. ANDERSON. Correct. He did.

Mr. MCDERMOTT. He just said it works very well.

Mr. ANDERSON. And we are investigating in Maryland whether or not we should expand it to the physician sector as well. So they physician is taking a look at that issue along with the politicians.

Mr. MCDERMOTT. Thank you.

Mr. CARDIN [presiding]. If I might just follow up on that one point, one of the concerns I have about the Maryland all-payer rate

system is that it works well; it has been—there is a lot of credibility among the providers that we are treating each of the providers fairly in the way that the rates are set; there is no discrimination against a facility that wishes to have a larger proportion of Medicare patients, because everybody pays the same rates. We, of course, still have a problem with uncompensated care that we are trying to deal with, and if we get universal coverage, then we will not have to worry about the uncompensated care.

But what worries me is that if the pressures become so great to reduce cost, will a Maryland all-payer rate system be able to survive, if the Medicare is arbitrarily reduced and more cost-shifting occurs nationwide between the government programs and the private sector?

Will we be able to maintain a system by trying—what is going to happen if we get our rates so low in our State, what is going to happen to the availability of health care providers or hospitals? Will it be able to do that?

Mr. ANDERSON. I obviously cannot predict the future. But if I look at the past, the rate of increase that Maryland has had to work under has been the Medicare rate of increase, which has been less than the private sector rate of increase and less than the overall rate of increase.

And so Maryland has been able to do this over an 18-year period, working under a constraint which is less than the rate of increase in the overall health care sector and the rate of increase in the hospital sector.

So I think if you look at the past, Maryland has been able to do it. Will they be able to do it in the future, I cannot predict. The hospital administrators are still enthusiastically endorsing this system, and they look at their crystal ball, and they still are strongly supportive of the system that you created.

Mr. CARDIN. Well, let me thank both of our witnesses for being here and braving the weather to appear before our committee. We thank you very much.

Mr. CARDIN. The next panel will consist of Hon. Arthur Flemming, chair and former Secretary of Health, Education, and Welfare, representing the Save Our Security Coalition; Sara S. Nichols, staff attorney for the Public Citizen's Congressional Congress Watch; Lawrence T. Smedley, executive director of the National Council of Senior Citizens; Dr. Michael A. Walker, executive director of the Fraser Institute from Vancouver, Canada; and Dr. William MacKillop, director of Radiation Oncology, Kingston Regional Cancer Center, Ontario Cancer and Research Foundation, Queens University, Kingston, Ontario.

Welcome.

Mr. Flemming, it is always a pleasure to have you before the committee.

STATEMENT OF HON. ARTHUR S. FLEMMING, CHAIR, SAVE OUR SECURITY COALITION, AND FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. FLEMMING. I am delighted to be here, and I appreciate the opportunity of presenting some of my views at this point relative to a great national debate.

Sixty years ago, our national community, in the midst of the greatest depression we have ever experienced, heard Franklin Roosevelt's challenge to pool our resources in both the public sector and private sector in order to help our people deal with the hazards and vicissitudes of life.

I was a reporter then on the staff of what is now the U.S. News & World Report. I saw the national community respond to President Roosevelt's challenge by launching our Social Security program.

I later joined the Roosevelt Administration as a member of the U.S. Civil Service Commission and had the opportunity of helping on the implementation of that program.

Now I am hearing President Clinton challenge our national community as we move out of a serious recession to pool our resources in both the private sector and public sector in order to help our people deal with the hazards and vicissitudes of health care.

We are truly thankful that the national community, as it existed 60 years ago, turned Franklin Roosevelt's vision for universal coverage into reality. The national community, as it exists today, I believe will turn President Clinton's vision for universal coverage of health care into reality. If it does, our children, grandchildren, and great-grandchildren will have reason to be truly thankful.

I want to do everything I can to see this happen, to see us reach the objective of universal coverage for all our people.

I feel that it is unnecessary to spell out again the hazards and vicissitudes in the field of health care that confront our Nation, and I will not do it.

I represent a group who are delighted that President Clinton has stated unequivocally that the health care plan must contain a provision that guarantees that all of our people have coverage of the health care benefits that are spelled out in the law. He has included in his plan the provisions that are needed if this guarantee of health care coverage for all is to be achieved. His plan is a genuine pooling of resources from the public and private sectors. All of us will have the satisfaction of contributing some of our resources to the pool, no matter how small. Then all of us will be permitted to draw from the pool when and if we are confronted with the hazards and vicissitudes of health care.

Also the group I represent rejoices in the fact that older persons, survivors, and the disabled not only will retain their present Medicare benefits, but will have added to these benefits prescription drugs.

For over 60 years, I have heard people debate various plans. But we have no plan. The time has come to stop our debate and act. At this point, I recommend the Clinton plan, because the Clinton plan guarantees coverage to everyone for the health care benefits set forth in the law.

It will undoubtedly be changed in some ways as a result of Congressional hearings. But that fundamental principle will remain. And once again, that fundamental principle will be come embedded in our way of life.

I recognize that the executive branch, headed by the President, has decided that it is politically feasible to recommend to the country the kind of a plan that he has submitted to the Congress. I rep-

resent and recognize that under our system of checks-and-balances, you are now in the process of checking that judgment.

His plan is made up of various parts, all with the idea of achieving the objective of universal coverage. Undoubtedly some parts that are in his plan will be exchanged for other parts by the Congress. But I hope that the Congress and the President will continue to communicate with one another until they agree on a plan that will reach this objective. That is the one thing that I am interested in.

But let us get to the place where we learn by doing. We have had no experience with some of the recommendations in the Clinton plan. Some will work; some will not work. When recommendations do not work, let us change them. But let us begin by doing.

That is my theme. I feel after 60 years of watching this that this country desperately needs a plan which will provide a universal right of coverage for minimum benefits, and I hope that the negotiations that are now taking place between the Congress and the Executive will lead to the adoption of such a plan.

Thank you.

[The prepared statement follows:]

TESTIMONY OF ARTHUR S. FLEMMING
SAVE OUR SECURITY COALITION

I. Introduction

- A. Sixty years ago our national community, in the midst of the greatest depression we have ever experienced, heard Franklin Roosevelt's challenges to pool our resources, in both the public sector and private sector, in order to help our people deal with the hazards and vicissitudes of life.
1. I was reporter then on the staff of what is now the United States News and World Report.
 2. I saw the national community respond to President Roosevelt's challenge by launching our Social Security program.
 3. I later joined the Roosevelt Administration as a member of the U. S. Civil Service Commission and had the opportunity of helping on the implementation of that program.
- B. Now I am hearing President Clinton challenge our national community, as we move out of a serious recession, to pool our resources, in both the private sector and public sector in order to help our people deal with the hazards and vicissitudes of health care.
- C. We are truly thankful that the national community, as it existed sixty years ago turned Franklin Roosevelt's vision into reality.
- D. The national community, as it exists today, I believe will turn President Clinton's vision into reality.
- E. If it does our children, grandchildren, and great grandchildren will have reason to be truly thankful.
- F. I want to do everything I can to make this happen.

II. Body

- A. I feel that it is unnecessary to spell out again the hazards and vicissitudes in the field of health care that confront our nation.
 - 1. All I want to say is that I am convinced that because of these hazards and vicissitudes untold numbers of our people face premature death and millions of our people face unnecessary suffering.
 - 2. I am likewise convinced that unless we act and act now runaway prices for health care will make it impossible for us to straighten out our economy and promote the best interests of our people.
- B. I represent a group who are delighted that President Clinton has stated unequivocally that the health care plan must contain a provision which guarantees that all our people have coverage of the health care benefits that are spelled out in the law.
 - 1. He has included in his well-rounded plan the provisions that are needed if his guarantee of health care coverage for all is to be achieved.
 - 2. His plan is a genuine pooling of resources from the public and private sectors--all of us will have the satisfaction of contributing some of our resources to the pool, no matter how small.
 - 3. Then all of us will be permitted to draw from the pool when and if we are confronted with the hazards and vicissitudes of health care.

- C. Also the group I represent rejoice in the fact that older persons, survivors, and the disabled not only will retain their present Medicare benefits but will have added to those benefits prescription drugs and coverage in Federal-state programs of long term care.

III. Conclusion

- A. Over 60 years I have heard people debate various plans--but we have no plan.
- B. The time has come to stop our debate and act.
- C. I recommend the Clinton plan
 - 1. The Clinton plan guarantees coverage to everyone for the health care benefits set forth in the law.
 - 2. It undoubtedly will be changed in some ways as a result of Congressional hearings but that fundamental principle will remain--and once we adopt that fundamental principle it will become embedded in our way of life.
- D. Let's learn by doing.
 - 1. We have had no experience with some of the recommendations in the Clinton plan.
 - 2. Some of the recommendations will work; some will not work.
 - 3. When recommendations do not work let's change them; let us learn by doing.
- E. I urge that the national community respond to the vision and challenge of President Clinton to pool our resources, in the private and public sectors, and by so doing enable all of our people to deal with the hazards and vicissitudes of health care.

Mr. CARDIN. Thank you very much.
Ms. Nichols.

**STATEMENT OF SARA S. NICHOLS, STAFF ATTORNEY, PUBLIC
CITIZEN'S CONGRESS WATCH**

Ms. NICHOLS. Thank you. Good afternoon. I am pleased to be here to talk about the American Health Security Act, H.R. 1200. I am working with over 1,000 groups around the country who support this legislation and want to see it passed.

It is now clear to me with the scoring of the Congressional Budget Office yesterday of the Clinton plan that single payer is the only plan before the Congress which is deficit-neutral and saves enough money to cover everyone fully for the same amount we are spending now, including long-term care coverage. It is the only reform before the Congress which fulfills the President's goals of simplicity, savings, security, choice, and quality.

It is very important to understand, because it is stated and misstated so often, that a single-payer plan is a government-financed, not a government-run, system. It replaces the inefficient private insurers with one insurer, the Federal Government, and it leaves the entrepreneurial private delivery system in place. Doctors work for themselves, and hospitals are not owned by the government.

Some people have quipped that a single-payer system would have the inefficiency of the Post Office. I hasten to point out that if the insurance industry were running the Post Office, 37 million people would not receive mail.

H.R. 1200 bases itself on the Canadian health care system, and it has very much, and the authors of the bill, have very much learned from both the successes of that system and the mistakes of that system.

And in my written testimony, I have at some length expounded on that point and shown the extent to which H.R. 1200 improves on the Canadian system, and it does that partly because we spend 30 percent more per person on health care in this country than they do in Canada, so we can afford to provide better benefits; we can afford to have more comprehensive services; we can afford to have even more research and development of technology than they do in that system and than we do now with the savings that we can achieve. So it is truly the American Health Security Act.

I would like to spend a little time comparing single payer to the President's plan with looking at the particular goals that the President has set forth. I am not spending time comparing it to other plans before Congress, in particular the Cooper-Grandy plan that has been so much in the news, because I do not see that those are really serious attempts to provide universal coverage. I am focusing on the one other plan which actually makes an attempt to provide universal coverage.

First, as to simplicity, clearly single payer is much more simple than the President's plan. It could not be more simple. Everyone is in the same plan; everyone has the same benefits; everyone pays in, and everyone gets out. It removes a layer of bureaucracy, which is the insurance industry.

In contrast, the President's plan is so complex as to be virtually unexplainable. Instead of removing a level of bureaucracy, it adds

two new layers of bureaucracy, the health alliances and the managed care bureaucracy, if you are not currently in such a plan.

It has, you know, as we know, many different contingencies. People in Medicare stay in there. Employers over a certain amount can opt out. Others are in; they choose through their alliance. The plans have various different costs. They pay copayments and deductibles. While everyone may pay in the same amount to an alliance, the alliance will pay out different amounts to the different plans, depending on whether the people in those plans are sicker or poorer, and the subsidies are very complicated to figure out and have to be adjusted retroactively if they have not been done correctly.

As to savings, it has already been amply demonstrated here this morning that single payer saves more than any other plan and is the only plan that saves enough to cover—simultaneously extend universal coverage now and not in the future.

I cannot emphasize enough the importance of providing that savings now and not in the future.

The State of Massachusetts passed a plan in 1988 that was supposed to provide universal coverage. Six years later, the savings still are not there. They have given up all hope of universal coverage, and costs are higher than anywhere else.

The Clinton plan does not save enough money to pay for itself; \$74 billion it adds to the budget deficit.

And security, of course, the single-payer plan, because it saves money and because it is simple and because it is not employer-based and goes with you rather than your employer, your spouse, or where you live is ultimate security from cradle to grave, whereas the Clinton plan, because it is not fully funded and employer-based, may provide insecurity.

And the single-payer plan, of course, is the ultimate in choice, free choice of physician everywhere.

In closing, I would like to dispel the single biggest fallacy about the single-payer system and in relation to the President's plan in particular.

People often act as if and talk about these plans as if the President's plan is more market-based than the single-payer plan. In fact, both plans rely on a mixture of the public and private sectors to achieve their goals. Single payer combines the best of the public sector, fair financing, with the best of the private sector, entrepreneurial free-market medicine, whereas the President's plan combines intrusive—combines private sector inefficient financing with government intrusion into the delivery of the health care system and to the very choices that are made about medical care.

Single payer, the American Health Security Act, is by far the least intrusive and best option for reform before our country.

[The prepared statement follows:]

**TESTIMONY OF SARA S. NICHOLS
PUBLIC CITIZEN'S CONGRESS WATCH**

My name is Sara Nichols, I am a staff attorney and health lobbyist with Public Citizen's Congress Watch. Thank you Chairman Stark and to the other members of this committee for allowing me to testify on the American Health Security Act.

According to numerous studies by the Congressional Budget Office (CBO), single payer is the only health reform option before the Congress that has been shown to save money and deliver health coverage to every resident *simultaneously*. As such, a single payer plan is the only plan that can deliver on the President's nonnegotiable demand for universal coverage.

The American Health Security Act, H.R. 1200, introduced by Representatives Jim McDermott (D-WA) and John Conyers (D-MI) along with 90 other cosponsors, is the piece of legislation before the House of Representatives which best represents the single payer system.

Not only is H.R. 1200 the only reform before the Congress which actually provides universal coverage, it's the only legislation which fulfills the other laudable principles set forth by the President but not delivered by the President's plan: security, simplicity, savings, quality and choice.

Single payer is simple: everyone's in the same plan. It provides security because it is not employer-based. It saves more money than any other plan according to the General Accounting Office (GAO) and the CBO and provides full choice of provider. The President's plan is complex, saves little money, and therefore provides no security and little choice.

Unfortunately, neither H.R. 1200 nor the President's plan significantly improves the quality of medical care.

The most important thing to understand about the single payer system is that despite constant misstatements to the contrary, single payer is not government-run health care, it is government-financed health care with full and free choice of doctor.

While the Canadian system provides an excellent model for an American health system, it is possible to improve on the Canadian system. H.R. 1200 has done just that. Its sponsors learned from Canada's successes, and its mistakes, and they have adapted the bill to the American health care crisis and system. Although it could adopt still more from the Canadian experience, H.R. 1200, as we will demonstrate, is truly the *American Health Security Act*.

II. THE SINGLE PAYER SYSTEM

The basic notion of single payer is very simple. The "single payer" refers only to the financing of health care. The inefficient wasteful multiplicative financing of the nearly 1500 private health insurers is replaced by a single government insurance fund. All of the private expenditures currently in the health care system are converted to public financing collected through the tax system.

The primary model for the single payer system which we rely on in this country is the Canadian system. There are other nations in the world that have workable universal national health care programs. While features of these other systems could no doubt play a role in any good health care system here, we think the single payer Canadian-style system is the most adaptable to the American palate because it is government-financed, not government-run. The distinction is important.

In a government-run system doctors work for and hospitals are owned and operated by the government. The often-derided British health care system is an example of this model. In contrast, in a single payer system like Canada's, the claims are processed by the government, but the doctors work for themselves and hospitals are privately owned and operated.

While Americans can be easily convinced of the merits of a public insurance fund over 1500 private insurance funds, they would be much more skeptical about the idea of providers, clinics and hospitals being government-owned and operated.

It is incorrect to think of the Clinton health plan as more market-based than the single payer plan. In fact, both plans depend on a mixture of the public and private sectors to achieve health system reform. In our estimate a single payer system combines the best of the public sector—fair financing—with the best of the private sector—entrepreneurial private practice medicine. The Clinton health plan,

on the other hand, combines inefficient private sector financing with intrusive government restructuring of the health delivery system. The single payer plan is the better and less intrusive option for the American medical and political system.

A. Universal Coverage. Single payer has as its most basic feature universal coverage because single payer starts with the premise that health care is a right; neither a benefit, nor a privilege, but a right. If health care is a right, our government has a duty to provide basic health services to all its residents, not just the rich ones or the poor ones, nor the employed ones nor the unemployed ones, nor only the legal residents. *Under single payer, all the residents of the United States could be covered fully for the same amount we are spending now.*

B. Cost Controls. Single payer is the only health reform before the Congress which controls costs enough to cover every person in this country fully for the same amount we are spending now. In 1993, health care bureaucracy consumed 24.7 cents of every health care dollar, \$232.3 billion.¹ By switching to a single-payer system, we could have saved in 1993 at least \$117.7 billion; \$456 for every American, or \$3,325 per uninsured person. These savings include \$49.1 billion (60.1 percent) on hospital administration,² \$23.8 billion (28.3 percent) on overhead in doctors' offices, \$1.6 billion (13.3 percent) on nursing home administration, and 34.2 billion (79.6 percent) on insurance overhead.³ This is enough to fund universal access for the uninsured and improve benefits for the tens of millions of Americans who currently have only partial coverage without any increase in overall health spending.

Single payer would achieve savings in insurance overhead by replacing the nearly 1500 private payers of health insurance claims with one "payer," the federal government. The hospital administrative savings come from global operating budgets and reduced billing costs associated with direct reimbursement by the government.

And finally, the single payer system, like every universal coverage health care system in the developed world, controls costs by negotiating providers' fees, and pharmaceutical costs.

C. Comprehensive Benefits. Single payer is the only health reform system before the Congress that can afford to provide comprehensive benefits. Because single payer controls costs better than any other system, it allows us to stretch dollars further getting as much value as possible from our phenomenal health spending.

In 1993, Canada spent 38 percent less per person than the U.S. did and was able to guarantee every Canadian comprehensive major medical coverage including full primary care treatment. Because we spend so much more, we can afford to provide better benefits than in many provinces in Canada, benefits like mental health coverage, full long term care and dental coverage. Since we can afford it if we use our money more efficiently, we should provide what everyone really needs, not just the bare minimum. We need full coverage for all the people in this country, not just the few who can afford it.

D. Accessibility. Single payer is fully accessible. There are no financial barriers to care or treatment. There are no copayments or deductibles in a true single payer system. Because there are no such "cost-sharing" provisions, people can go to the doctor whenever they need to, not just when they can afford to.

The Clinton plan, in contrast, relies heavily on shifting costs to health consumers, requiring families to pay as much as \$3,000 a year out of pocket on top of

¹Hellander, Ida M.D., Himmelstein, David M.D., Woolhandler, Steffie, M.D., M.P.H. and Wolfe, Sidney, M.D., "Health Care Paper Chase, 1993: the Cost to the Nation, the States and the District of Columbia," from Physicians for a National Health Program, Chicago, IL; The Center for a National Health Program Studies, Harvard Medical School/The Cambridge Hospital, Cambridge, MA; and The Public Citizen Health Research Group, Washington, D.C.—August 1993.

²Woolhandler, Himmelstein, *New England Journal of Medicine*, August, 1993.

³*Ibid.*, "Health Care Paper Chase."

20% copayments. These cost shifts create an illusion of lower premiums and health costs while simply forcing consumers to pay three additional ways, through their taxes, through lost wages and through out-of-pocket expenses.

Some argue that we can't afford to break down these barriers, that we *need* cost-sharing in order to bring in more revenue and deter people from seeking unnecessary care. The reality is that by paying into a tax-based system, we all are sharing costs. We all will need to access the health care system at some point in our lives. So-called "cost-sharing" deters as much needed care as it does unnecessary care and in so doing drives up the cost of health care because by the time people come to the doctor, they are generally sicker and more expensive to treat.⁴

E. Freedom of Choice. Single payer allows people full choice of provider, even improving over the current choices people have in this country. In a single payer system, you're provided with a health security card. That card guarantees you full coverage at the provider of your choice. You take that card to the provider of your choice anywhere in the country and you're covered. The provider sends the bill to the government instead of billing you and your insurance company.

In contrast, the Clinton Health Security Card does not guarantee *coverage*. It guarantees only universal *access*. The difference between access and coverage is important. In theory, everyone has *access* to the finest hotel in town, but only if you have the money to pay. In our current health care system, the insurance companies restrict both *access* and *coverage*. The Clinton health plan cures only the access question, without providing coverage.

F. Portability. A single payer system is fully portable. Instead of coverage being dependent on where you work, who you're married to, or where you live, your coverage goes with you and stays with you, no matter where or whether you work.

G. Public Accountability. A single payer system is publicly accountable. Instead of decisions about your health needs being made by insurance bureaucrats, decisions are made by accountable, fairly-comprised health boards which are answerable to the public through the political system.

III. CANADA'S VERSION OF SINGLE PAYER

The Canadian version of single payer is most illustrative of what we want to provide here because it works, it's close to home, and Americans have heard about it.

The Canadian system is able to deliver universal health care to all its residents with no barriers to receiving care, and it does so at 38% less per person than the cost of the American system.

A. Federal Minimums. In Canada, the single payer system evolved from province to province, and the administration of the systems varies by province. But there are certain features that never vary:

1. Copayments, deductibles and other "cost-sharing" devices are barred by law;

2. Provinces have local health boards which negotiate fees with physicians and drug companies;

3. Provinces have mandated separate capital and operating budgets; and

4. Hospitals run on global operating budgets which are determined on a capitated basis (based on the number of patients served).

B. Provincial Jurisdiction. While the Canadian federal government provides these basic standards, it allows other features to be controlled and determined at the provincial level. Some examples of provincial discretion include:

1. The extent of the benefits provided;

2. Whether the physician is reimbursed on a strictly fee-for-service basis or a salaried basis; and

3. How much money is allocated to capital development such as the building of new high tech equipment, etc., vs. allocation to operating expenses.

In all, the single payer system, modelled on Canada, is not just the best plan for consumers, but the only plan that provides what consumers need.

⁴Russell, Edith, Ph.D.—Economic Policy Institute.

IV. H.R. 1200, AMERICAN HEALTH SECURITY ACT

H.R. 1200 takes the basics of the Canadian health care system and adapts it to the United States. Most of the familiar features of the Canadian system make the journey intact: H.R. 1200 provides comprehensive benefits for all Americans for the same amount we are spending now to cover only a portion of the population. It does so not only by replacing the inefficient private insurance financing with public financing, but by employing global operating budgets for hospitals, and insuring negotiated fee schedules for providers and drug companies. In all, H.R. 1200 is the best representation of a single payer system currently before the Congress, containing the only structure capable of guaranteeing health care to the nation.

In this section, because I have already extolled the virtues of a single payer system, I will concentrate on the ways in which H.R. 1200 improves on the Canadian system and point out a few places where it falls short. While the foundations of this house are sound, we aim to take a closer look at its curtains and furnishings as well.

A. Decentralization. H.R. 1200 adapts itself to the American political and economic system by decentralizing the running of the business of health care. Under H.R. 1200, while the federal government would collect the premiums and set minimum standards for benefits and allocation of resources, it is up to the state and local governments to decide how to use those resources, beyond a standard benefit package.

There are aspects of this decentralization which are excellent. In general, it is preferable for states and local communities to make decisions with regard to the fair allocation of resources rather than the federal government. In theory, as long as those decisions are publicly accountable, the resources stand a good chance of being fairly distributed, especially when compared to the current health care system.

Nonetheless, there are some basic aspects to a single payer system which must not be left up to the states, they must be set by the federal government. The most important central principle which is left out of H.R. 1200 is the principle of *mandated* separate capital and operating budgets for hospitals and other health providing institutions.

H.R. 1200 fails to mandate such separate budgets. Instead, it specifies simply that states must have budgets for capital and operating expenses and leaves it up to the states to decide whether to merge or split these budgets.

Granting latitude in this area subverts a fundamental precept of a successful single payer system: namely, that without this mandate of separate budgeting of capital and operating expenses, there is no guarantee of halting the out-of-control "medical arms race" which has eaten up our health care resources and dramatically increased the cost of medical care.

Unless capital and operating expenses are paid for and budgeted for separately, nothing is to prevent the local health boards set up by H.R. 1200 from siphoning off money badly needed to operate existing facilities and devoting it instead to building yet another lavish duplicative facility aimed at attracting wealthy patients. We must ensure that basic medical facilities and equipment are kept well-staffed and running smoothly before we turn toward expanding machinery and facilities in a given metropolitan area and worsening the wasteful current situation in which there are 300,000 empty hospital beds in the U.S.. *H.R. 1200 must be amended to match its companion bill in the Senate, S.491, which mandates separate capital and operating expenses.*

B. More comprehensive coverage. While most provinces in Canada have made the decision to guarantee at the federal level only major medical expenses, we can afford more coverage than that here because we spend nearly one-third as much per person per annum as they do in Canada.

H.R. 1200 has gone a long way towards providing those comprehensive benefits. It federally guarantees full major medical coverage, prescription drug coverage, a basic package of mental health benefits, dental care for children up to 18, and long term care and home and community-based coverage for those who meet the requirements. States are free to provide benefits beyond the federal package, but they cannot choose to cover less than the federal minimum.

Although we applaud the high level of medical benefits guaranteed by the U.S. government in relation to Canada, we think we can and should do better. We have enough money in the system to eliminate the arbitrarily low cap on mental health benefits, to provide dental care for all Americans, and to provide long term care (especially home-based care) for people who need assistance with only one Activity of Daily Living (ADL), instead of 2, as the bill provides.

C. Increasing the number of primary care practitioners. H.R. 1200 recognizes that giving everyone a health security card to present to the provider of his or her choice is meaningless if no such provider is available and accessible.

In fact, we have a critical shortage in this country of primary care practitioners that Canada does not have. 2/3 of the physicians in this country are specialists to 1/3 primary care practitioners. In most other developed nations including Canada, the ratios are reversed, 2/3 primary care practitioners to 1/3 specialists. Reversing these ratios here would not only increase the availability of the providers whom patients need most and most often, but it would further bring down the cost of health care by encouraging earlier and less expensive care over costly specialized medicine.

H.R. 1200 has sought to address this problem by setting strong goals for the national health board to work towards and establishing funding for those goals. Some of those methods include:

1. Within 5 years of enactment, 50% of the residents in medical residency education programs will be primary care residents;
2. The national board will reduce payments to state health security programs that fail to meet this goal;
3. The bill also seeks to increase the number and use of clinical primary care practitioners, certified nurse midwives, physician assistants and other non-physician practitioners; and
4. The bill revives and uses the National Health Services Corps and Public Health Block Grants to accomplish these goals.

D. Increasing the number of primary care facilities. Another problem with our current health care system is a critical lack of facilities and medical personnel in poorer areas in our inner cities and in many sparsely populated and poor rural areas. H.R. 1200 seeks to increase the number of good primary facilities in previously underserved communities in the following ways:

1. Establishing block grants to develop primary care centers which will serve medically underserved populations. Such centers would include migrant health centers, community health centers or other qualified health centers.
2. The bill also encourages and creates Community Health Service Organizations (CHSOs) to serve previously underserved communities and areas. These CHSOs are basically qualified HMOs which are designed to fill the vacuum created by a lack of health facilities.

Although we applaud any effort to create facilities and service for previously underserved communities, we fear the CHSOs will not work because the bill allows them to be for-profit entities. Any feature which encourages for-profit HMOs to start and flourish in the future is anti-consumer in effect. In order to maximize profits, for-profit HMOs tend to divert money earmarked for care to profit, engage in excessive marketing, and pay high executive salaries, all at the expense of care. In general, HMOs and other managed care facilities attempt to save money by reducing the amount of care provided. There is no evidence that such efforts consistently control costs. Global operating budgets and negotiated fee schedules control costs.

Unfortunately, the legislation distinctly fails to forbid profiteering at the expense of care. In the companion legislation in the Senate, S. 491, there is a provision that specifically forbids the creation of new for-profit HMOs and ensures that existing for-profit facilities cannot divert excess dollars to profit over a reasonable rate of return on their capital investments. This arrangement has already proved successful with not-for-profit hospitals in the U.S.. *To fulfill its goals, H.R. 1200 must be amended to include such provisions.*

E. Universal Coverage. H.R. 1200 saves enough money to provide universal

coverage *immediately upon enactment*, rather than "when the savings are achieved," as the Clinton plan provides. Any plan which defers universal coverage to a time in the future—even a specified time—is insufficient to address our current health care crisis. The Clinton plan, because it does not save enough money now, projects universal coverage into the next millennium. This is unacceptable and doomed to failure.

The experience of Massachusetts is illustrative. In 1988, the Massachusetts legislature passed a health reform plan based on the so-called "pay or play" model. The idea was that universal coverage would kick in once sufficient savings were realized. Because the plan had woefully insufficient cost controls, the savings were never realized. 6 years later Massachusetts suffers from nearly the highest health costs in the country, one of the highest penetrations of HMOs, and has given up on achieving universal coverage with that system. H.R. 1200 fulfills the essential goal of saving enough money to provide universal coverage immediately.

Although H.R. 1200 saves enough money to cover everyone, it actually leaves at least 3.2 million people out. One area where H.R. 1200 does not improve on the Canadian system is in its definition of universal coverage. The bill has confined its coverage to *legal* residents of this country, rather than all residents. This is ultimately a self-defeating and unworkable distinction.

To take seriously the idea that health care is a right, rather than a privilege or a benefit, means providing health coverage to all people who reside in this country regardless of immigration status. It is immoral, unethical and unjust to exclude the 3.2 million undocumented workers of this country and their families from our health services. We cannot say "one plan for all," and then define the "all" as we like.

Since the system will eventually pay for sick undocumented residents one way or another, it would be far cheaper on the system to provide full coverage including preventive medicine. Allowing any group of patients to be excluded from "universal" coverage creates the same expensive cost-shifting as the status quo.

We are already paying for the care of undocumented immigrants. In 1993, it cost the United States government \$300 million to provide emergency care to undocumented workers in Texas, California, New York and Illinois alone. Study after study shows that undocumented residents, like all of the uninsured, use our health care system whether covered or not. They show up at emergency rooms about to give birth to an unhealthy baby or they arrive in the advance stages of a debilitating disease and our hospitals treat them, because they must. If those hospitals and medical personnel are not reimbursed for treating undocumented people, it strains our resources and puts an added burden on state and local governments to pick up the tab.

Undocumented workers contribute to our economy. They buy goods and services, they pay rent and often they even pay taxes. According to the Center for Constitutional Rights in New York, the amount they contribute to our economy outweighs or counterbalances the cost of providing health services to them. Yet because of xenophobia and lack of leadership, we seek to deny them care.

Ironically, if for no other reason, we should cover undocumented immigrants out of fear. Diseases know no boundaries of legality. A sick undocumented child resident can infect your child as easily as a documented child. To protect all the legal residents of this country we must provide health coverage to the undocumented.

F. Public Accountability. H.R. 1200 dictates the composition of local health boards ensuring a balance of consumer, physician and medical industry representation on the boards. There is also an attempt to achieve nonpartisan balance on the federal boards. These efforts are to be applauded because they represent a dramatic increase over our current health care system in the amount of accountability to the public.

The public accountability portions of the bill would be strengthened greatly by facilitating the creation of an independent consumer-funded watchdog organization modelled on the successful consumer utility board (CUB). Such a watchdog, funded by voluntary contributions, would monitor local health boards, insuring that they were accountable to the public.

G. Financing. Because a new financing section to H.R. 1200 was introduced just last Thursday, we have not had a chance to review it thoroughly. Our initial impression, however, is favorable. Again adapting to the American political realities, the bill relies primarily on a payroll tax which is capped at a percentage of payroll depending on the size of the business. The new package has eliminated the increases in the top income tax brackets which the old funding package had included. It has added a \$2 cigarette tax and a 50 percent excise tax on handguns and ammunition.

In general, an income tax is preferable to a payroll tax as a funding mechanism because it is progressive rather than taxing at a flat rate. However, when compared to an employer mandate such as the Clinton bill contains, a graduated payroll tax like this is much less regressive.

The \$2-per-pack cigarette tax increase is very necessary and long-overdue. Such an increase would reduce the number of smokers over time, particularly by discouraging people from ever starting smoking. We applaud its inclusion, and that of the gun tax, in the bill.

H. Quality. H.R. 1200 is the only health reform bill currently before the Congress that does nothing to *lessen* the quality of medical care by restricting consumers' legal rights.

V. COMPARING H.R. 1200 TO THE CLINTON BILL

In setting forth his proposal for health care reform, President Clinton established several laudable goals for what such reform should achieve, namely: simplicity, security, savings, choice and quality. Unfortunately, the Clinton Health Security Act is structurally incapable of achieving those goals. The only health reform proposal before the Congress which achieves these goals is H.R. 1200/S.491, the American Health Security Act.

A. Simplicity. H.R. 1200, the single payer plan, is *simple*; everyone is in the same plan, with the same benefits, no matter where they live, work or what their income level. In contrast, the Clinton health plan is so complicated as to be virtually unexplainable, to say nothing of the expenses of funding these "complications." Rather than removing bureaucracies, the plan inserts two new layers--the health alliances and the HMOs--between you and your doctor.

The Clinton plan is confusing and unfair because it establishes and institutionalizes different tiers of care depending on one's income, age and place of employment. Seniors continue to receive Medicare; Medicaid recipients go into the new system with reduced benefits; people buy care through newly created "health alliances;" the level of care depends on ability to pay for more expensive "fee-for-service" care and if you can't, you have to join an HMO. Large employers can opt out of the plan altogether.

If people and businesses cannot afford to pay their health premiums, they are subsidized (as soon as the savings are achieved and then for as long as they last) by the federal government. The Health Alliances have to figure out how much to subsidize each person based on their income level, the size of their business, etc. If the subsidy was wrong it will have to be adjusted retroactively. The amount of complexity these contingencies generate is difficult to overestimate. The Clinton plan could not be less simple.

B. Savings. H.R. 1200 would save upwards of \$117 billion in administrative waste and more by going to a single payer system and by setting global budgets and fees. According to figures released by Rep. McDermott last week, 75% of consumers would pay *less* out of pocket for health care than they do now. Single payer saves money.

Soon we will know from the Congressional Budget Office exactly how much savings the Clinton plan can produce. Preliminary estimates show the plan achieving marginal savings by "streamlining" the insurance paperwork--\$6 to \$8 billion a year. At the same time, the Clinton plan adds a cost of \$21 billion a year to pay for the new layer of bureaucracy--the health alliances.⁵

⁵Himmelstein, David and Woolhandler, Steffie, 1993.

Competition amongst health plans provides illusory savings at best. Managed competition will hasten the existing trend in this direction. Already 45% of all HMOs are owned by the 5 largest insurance companies—CIGNA, Aetna, Prudential, The Travellers, and MetLife.⁶ Because it is likely that the plans will eventually be owned by only a few giant corporations, an oligopoly will result. Oligopolies have no incentive to compete; they instead act in concert to enlarge the size of the pie so that they can all have a bigger piece of it.

Furthermore, the plan contains no global operating budgets, and no negotiated fee schedules for physicians or pharmaceuticals (outside of the government-controlled Medicare which is squeezed to find new money to fund the uninsured). The plan is virtually incapable of saving enough money to cover the new people it hopes to bring in.

On an individual level, there is little in the way of savings either. Individual consumers will have to pay high out-of-pocket expenses in the form of co-payments and deductibles. Although estimates on the individual savings vary, it is clear that the number of people who will pay less under the Clinton plan for health care does not begin to approach the 75 percent of us who will pay less under H.R. 1200. The Clinton plan does not produce sufficient savings to pay for universal coverage.

In contrast, the CBO and General Accounting Office (GAO) have consistently found not only that single payer is the only health reform before the Congress which saves money, but it is the only plan which saves money while providing universal coverage *simultaneously*.

C. Security. H.R. 1200 provides complete security because coverage goes with the person not her job, her spouse or her place of residence. All are covered under H.R. 1200 from cradle to grave and no one can take it away.

Because it is employer-based and under-funded, the Clinton health care plan cannot provide Americans with badly-needed health security. As long as the type, extent and quality of health care coverage received is dependent on employment status, we're all at risk because we may lose or change our jobs. The Clinton health care plan depends entirely on employers to cover the workers of this country. The rest of us are financed by money (nearly \$285 billion) which is siphoned from the Medicare system by "slowing its growth rate." Such financing is so flimsy that it reinforces rather than alleviates the current insecurity of Americans about their health care.

D. Choice. Perhaps the biggest fallacy about a single payer system is that it would restrict choice. H.R. 1200 provides a real choice of provider because consumers can take their Health Security Card to the doctor of their choice. They can also go to an HMO or managed care facility if they prefer. Plans and doctors compete on the basis of quality, rather than cost. Managed care and fee-for-service medicine will only survive if consumers choose to go to them.

By design, the Clinton health care system restricts choice of provider. The main cost controls in the plan come from encouraging people to leave traditional fee-for-service plans and enter managed care plans. By making the fee-for-service option more expensive than HMOs, the Clinton plan would herd people into HMOs and away from free choice of doctor, unless they are wealthy enough to afford the other option. The President himself emphasizes choice of *plan* over choice of *provider*, acknowledging that the choice of provider is limited in his plan. What consumers really cherish is choice of provider not plan. Single payer provides that choice.

E. Quality. While the Clinton bill restricts consumers' legal rights to restitution from negligent providers, H.R. 1200 preserves consumers' rights and for that we applaud its sponsors.

Unfortunately, the applause ends there. Like all current Congressional health care proposals, *both* plans have ignored the vital concern of affirmatively protecting consumers from negligent providers. Although many plans pursue "quality assurance" through anonymous data collection, practice guidelines, and protocols, there are no provisions for meaningful regulation of the medical profession.

⁶Known as "the Alliance for Managed Competition."

Congress should pursue an affirmative agenda of consumer protection highlighted by medical malpractice prevention and consumer empowerment.

Specific suggestions include:

1. Reducing the number of unnecessary deaths and injuries caused by negligent medical treatment by creating a comprehensive medical malpractice prevention program;
2. Developing independent, publicly-accountable state medical boards;
3. Establishing more stringent physician licensing and discipline procedures;
4. Empowering health consumers by mandating reporting of information regarding incompetent health care providers; and
5. Authorizing consumer access to information regarding health care providers through the taxpayer-funded National Practitioner Data Bank.

VI. CONCLUSION

H.R. 1200, the American Health Security Act, is, despite some flaws, the best representation of a single payer system before the House of Representatives. More importantly, it is the only plan before the Congress capable of fulfilling the President's nonnegotiable demand of universal coverage.

In crafting this bill, the sponsors of H.R. 1200 have ingeniously adopted the strengths of the Canadian-system, while eliminating its few weaknesses.

As a government-financed system *with full choice of doctor* rather than a government-run system without, single payer is uniquely adaptable to the American system. In it, we could have competition which truly benefits consumers, between doctors on the basis of quality rather than between HMOs on the basis of cost.

Mr. CARDIN. Thank you very much for your testimony.
Mr. Smedley.

**STATEMENT OF LAWRENCE T. SMEDLEY, EXECUTIVE
DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS**

Mr. SMEDLEY. Good morning. It is a pleasure to be here today. My name is Larry Smedley. I am the executive director of the National Council of Senior Citizens.

After years of careful consideration of different approaches to health care reform, the National Council adopted a set of health reform principles which determine which specific legislation merits our support.

Mr. Chairman, the health system that best incorporates our principles is the single payer approach embodied in the legislation introduced by Jim McDermott and Senator Wellstone, H.R. 1200 and Senate bill 491.

Single payer provides a sensible approach to most of our health care problems. It will reach every resident of this country and guarantee that their health care needs will be met. It will be paid for fairly through a progressive income and business tax system with those who can afford paying a fair share.

Single payer finally allows us to get a solid handle on costs that are spinning out of control. Single payer will expand benefits for all Americans, provide an array of preventive health care services, prescription drugs, long-term services keyed to community and home-based supports.

Finally, single payer keeps the private health delivery system intact and builds on the strength of that system.

Passage of a single-payer system is the ultimate goal of the National Council. However, our arrival at that goal may not be as direct as we might wish.

As you know, the President of the United States has introduced a comprehensive plan to cover all Americans. We have examined the President's bill in the context of our own health care principles. We have found many reasons for senior citizens to support his health proposal.

Universal coverage is guaranteed by 1998, and that is the key reason that the National Council believes that the President's plan advances the health reform debate. No other health care proposal, other than single payer, comes close to meeting this goal.

The bill has strong cost containment. If we, as a Nation, cannot hold down the spiraling growth in private health care expenditures, we will never be able to achieve any meaningful, long-term deficit reduction or needed domestic improvements.

Under the President's bill, Medicare is strengthened with the addition of a prescription drug benefit with capped out-of-pocket cost, and balanced billing is finally eliminated under Medicare.

Pre-Medicare or early retirees are also covered. While some in Congress may see this as a boon to those corporations who now provide retiree health benefits, it is actually a necessary component of reaching universal coverage.

And though the bill has some good features, which I have outlined, this does not mean that the National Council believes the

Clinton bill to be without flaw. There are key improvements we would like to see—

Mr. CARDIN. Mr. Smedley, let me interrupt you just for 1 minute, and I apologize for doing that.

There are 3 minutes left on a vote. I was hoping that Mr. Stark would be back.

I am going to have to declare a short recess, and we will reconvene within 5 minutes. I would ask the witnesses to please stay at the table. We should be able to reconvene within 5 minutes, and I very much apologize for the interruption.

[Recess.]

Chairman STARK [presiding]. Mr. Smedley, I am sorry. If it were not for the weather, this system would work much more smoothly, and we would not have interrupted your testimony.

Mr. SMEDLEY. Oh, that is understandable, Mr. Chairman.

Chairman STARK. Please, if you would like to pick up wherever in your testimony you care to. Thank you.

Mr. SMEDLEY. I will pick up where I left off.

Although the bill has all these good features—I am referring now to the President's bill—this does not mean that the National Council believes the Clinton bill to be without flaw. There are key improvements we would like to have made in the bill as drafted. Unfortunately, some of them are highly technical, and time does not permit me to go into them today.

Chairman STARK. Give us a hint.

Mr. SMEDLEY. Well, you can ask some questions, if you so desire, Mr. Chairman.

Chairman STARK. I want to know what those overly technical issues are.

Mr. SMEDLEY. Mr. Chairman and members of the subcommittee and Members of Congress, you will be hearing from us on these and other issues as health care legislation goes through Congress.

Mr. Chairman, in conclusion, the National Council believes that national health reform debate now centers on the President's bill, H.R. 3600.

Nevertheless, we now that a single-payer system will be adopted by this Nation one day, and we are going to do all we can to further that day along. This is one reason where we are going to be fighting very hard for Congress to pass the single State option the President included in his bill.

We support the President's bill because we see that the bill is laying the foundation of a national and efficient system of health care. We will be working with the Congress and this subcommittee to bring the Clinton plan in line with as many single-payer principles as we possibly can, and with your help, our members' hard work, and God's blessing, we will enact the most fundamental restructuring of the health care system in our Nation's history.

Thank you.

[The prepared statement follows:]

Testimony of Lawrence T. Smedley
Executive Director
National Council of Senior Citizens

Introduction

Good morning, Mr. Chairman, members of the Subcommittee. It is a pleasure to be here today. My name is Lawrence T. Smedley. I am the Executive Director of the National Council of Senior Citizens (NCSC). NCSC represents over five million older and retired Americans nationwide through our 5,000 affiliated clubs and Councils. The National Council was founded in 1961 to lead the fight for Medicare. After its enactment—an event we considered to be the first step in the creation of a universal national health care system—the Council continued its work on health reform. At the same time, we expanded our commitment to programs for older workers, transportation, housing, civil rights and Social Security and pension protections. Our work is not just for today's retirees, but also for current workers who will one day enjoy the fruits of their labor and for younger persons not yet in the workforce.

Health Principles

Over the decades, the National Council has debated which way this nation should provide health care to all its citizens. After careful consideration of many different approaches, our membership and General Policy Board adopted a set of health reform principles. The principles are used by our officers and legislative staff to determine if specific legislation merits the support of the National Council. The health reform goals of this organization and America's seniors are incorporated in these principles. They are:

- Universal coverage, with everyone in the same system.
- Comprehensive benefits so that all medically necessary services will be provided to all without multiple tiers of benefits based on income, age or other extraneous factors.
- Costs must be controlled throughout the system.
- Financing must be fair and progressive.
- Cost sharing must not create barriers to receiving care and must not be relied upon to finance the system.
- Quality must be strengthened with consumer protections.
- Health planning must be undertaken to allow all our citizens equal access to high-tech medicine.
- Patients' rights must be spelled out to guarantee the timely delivery of services.
- The Federal government and states must oversee the program to ensure a strong role for consumers in the administration of the program.
- Finally, whatever system is adopted must point the way towards a single-payer system.

Single-Payer

Mr. Chairman, the health system that best incorporates these principles is the single-payer approach embodied in the legislation introduced by Congressman Jim McDermott (D-Wash.) and Senator Paul Wellstone (D-Minn.)—H.R. 1200/S. 491.

Single-payer provides a sensible approach to most of our health care problems. It will reach every resident of this country and guarantee that their health care needs will be met. It will be paid for fairly through a progressive income and business tax system with those who can afford paying a fair share, while lower-income people will not see their tax burden increased. Under the Wellstone/McDermott bills, up to 90 percent of all Americans will see their overall health care spending decrease.

Single-payer allows us to finally get a solid handle on costs that are spinning out of control. (NCSC believes that the current trend showing slower growth in overall health spending is a cynical manipulation of the system by the insurers and providers of health care to lull us into believing there is no financial crisis.) Only through system-wide cost controls will we be able to put an end to providers being able to pit one group against another (e.g., raising private pay rates to make up for falling Medicare and Medicaid rates).

Single-payer will expand benefits for all Americans. It will allow us to provide an extended array of preventive care services to keep people healthy, prescription drugs to maintain that health, and long-term care services keyed to community and home-based supports rather than to institutional services.

Finally, single-payer keeps the private health delivery system intact and it builds on the strengths of that system.

Passage of a single-payer system is the ultimate goal of the National Council. However, our arrival at that goal may not be as direct as we might wish.

President Clinton's Legislation

As you know, the President of the United States has introduced a comprehensive plan to cover all Americans. We examined the Clinton bill in the context of our own health care principles. We have found many reasons for seniors to support the Clinton health proposal.

Universal coverage guaranteed by 1998 is a key reason the National Council believes that H.R. 3600 advances the health reform debate. No other health care proposal, other than single-payer, comes close to meeting this important goal.

Strong cost containment: If we as a nation cannot hold down the spiraling growth in private health care expenditures, we will never be able to control Medicare and Medicaid costs—leaving us unable to achieve any meaningful, long-term deficit reduction or needed domestic investments.

Under H.R. 3600, Medicare is strengthened with the addition of a prescription drug benefit with capped out-of-pocket costs. Balance billing is finally eliminated under Medicare. NCSC fought for many years, both here in Congress and in State Houses across the nation, to have this onerous and regressive cost-sharing provision removed from the Medicare program.

Pre-Medicare or "early" retirees are covered. While some in Congress may see this as a boon to those corporations which now provide retiree health benefits, it is actually a necessary component for reaching universal coverage. Of the ten million pre-Medicare retirees, only about forty percent have any business-provided health insurance. Only four percent of all U.S. companies provide any retiree health benefits. This means six million older Americans are either buying individual insurance policies themselves, are utilizing government assistance or are going without such protection. The pre-Medicare retiree benefit is fundamentally not a business benefit, but a help to retired workers and their

families. Many of these people were "down-sized" out of the workplace. They would have continued working had their employer not told them they would get either a pension check or an unemployment check.

This President has taken leadership to acknowledge that meeting chronic care needs are as important as acute services. The creation of a non-means-tested long-term home and community-based care program for citizens of all ages takes the crucial first step of meeting chronic care needs that increase with age across the nation.

This same commitment to seniors' health needs of America cannot be found in the Cooper/Breaux bill which will eliminate all Federal support for long-term care forcing the states to pick up the difference. It cannot be found in the Michel/Lott bill which simply cuts reimbursement rates for Medicare making it harder for beneficiaries to find a provider. These pieces of legislation, and similar efforts, only take from Medicare and offer nothing in exchange.

The National Council strongly believes that the useful debate should not be between the so-called "Clinton-lite" plans and Clinton, but rather between H.R. 3600 and H.R. 1200. As the polls show, it is not a matter of how far the American people want to go, it is a question of how far Congress is willing to hold us back from truly effective solutions.

This does not mean the National Council believes the Clinton bill to be without flaw. There are key improvements we would like to have made to the bill as drafted.

In order to create a single-tiered health care system and to eliminate the perception that older citizens could be treated as second-class medical citizens under H.R. 3600, we believe Medicare beneficiaries should be given the option to join a health alliance plan or return to Medicare during the open enrollment season. If a senior opts into the health alliance system, then Medicare should be required to pay the 80 percent average-weighted premium like Medicaid, rather than Medicare paying to the alliance what it would have paid had the beneficiary stayed in Medicare. The health alliance premium for an older citizen must, like their younger counterpart, be community-rated if we are to purge a major evil of the current insurance system of risk adjustments of premium by age.

We are also concerned about the ability of Medicare to absorb another \$124 billion in cuts. In order to mitigate these changes and stop the current trend of physicians turning away Medicare beneficiaries, we believe private-pay rates and Medicare rates should be linked together. By legislating that Medicare rates could not be lower than seven percent of the average reimbursement for a geographic location, Congress would ensure providers would not lack an economic incentive to see Medicare patients. Also, if the private-sector cost containment were more successful than anticipated, Medicare growth would fall more quickly. We also believe that the Congress should consider a hard-nosed anti-discrimination clause in H.R. 3600 assuring that Medicare beneficiaries will not lose access because of lower payments to providers.

In fairness, since the Clinton program provides financial protections to those at 150 percent of poverty or below, the Qualified Medicare Beneficiary (QMB) eligibility thresholds should be raised to this level. We would also like to see a Federal minimum benefit level specifying services established for the long-term home and community-based care program in order to establish a uniform set of support services throughout the states. The eligibility requirement should also be reduced from three activities of daily living to two based on a care manager's assessment of need.

Single-Payer Option

Mr. Chairman, the National Council believes that national health reform debate now centers on H.R. 3600. As I said earlier, we want that debate to continue and to incorporate the benchmarks established by the single-payer proposals. We know that a single-payer system will be adopted by this nation one day, and we are going to do all we can to further that day along. That is one reason why we are going to be fighting very hard for Congress to pass the single-payer state option the President included in his bill.

Several states are already interested in adopting a single-payer system and the Federal government should not prevent their doing so. The Congress of California Seniors, as you know, Mr. Chairman, is very much involved in the California Health Access campaign to pass a single-payer initiative in your home state. Canada did not adopt its successful single-payer structure overnight, rather it was enacted one province at a time. If that is what it will take to demonstrate the political commitment for this approach to our Federal legislators, then we are prepared to work for single-payer, state-by-state. What we will not support is a retreat from basic assumptions of the President's proposal. That would betray the principles demanded by our members.

Goals of the National Council of Senior Citizens

This organization has not backed away from our single-payer support. We support the Clinton bill because we see the Clinton bill as laying the foundation of a national and efficient system of health care. We will be working with the Congress and this subcommittee to bring the Clinton plan in line with as many single-payer principles as we possibly can. We will then use every resource we have available to ensure the passage of a progressive health reform package. We will oppose any and all legislation that does not meet our principles and sets back the cause of senior health care and the health needs of all citizens.

With your help, our members' hard work, and God's blessing, we will enact the most fundamental restructuring of the health care system in our nation's history. Thank you.

Chairman STARK. Thank you.
Dr. Walker.

**STATEMENT OF MICHAEL A. WALKER, PH.D., EXECUTIVE
DIRECTOR, THE FRASER INSTITUTE, VANCOUVER, CANADA**

Mr. WALKER. Thank you very much, Mr. Chairman. I must say I appreciate the opportunity to appear before your committee to bring you the results of the Fraser Institute's latest survey of hospital waiting lists in Canada.

First by way of introduction, the Fraser Institute is a federally-chartered, nonprofit research organization which conducts studies of public policy issues in Canada, and the Institute has published three book-length studies that examine Canada's health care system from different points of view. The latest study entitled "Caring for Profit" was conducted by professor Malcolm Brown, a self-professed advocate of Canada's approach to single-payer health care, just to give you the idea that we do not have a monolithic view on this topic.

The Institute also conducts an annual survey of physicians to determine the extent to which access to health care is rationed as a result of the fact that the demand for health care is steadily increasing, but the supply is limited by a series of budgetary caps.

The survey produces two measures of rationing, the waiting time for appointments to see a specialist and the waiting time for treatment once the specialist has been seen. Since all patients proceeding to either of these steps must first have seen a general practitioner for a referral, it can be reasonably assumed that those waiting represent a legitimate demand for care.

While a survey of specialists may be the only practical way to determine specialist waiting times, it is not the preferred way to measure hospital waiting lists. The Institute adopted this survey approach only after ascertaining that hospitals do not have the information required to build a comprehensive waiting list in Canada.

The publication of our surveys for the last several years has stimulated considerable interest in the area, and I am hopeful that within several years Provincial governments will publish comprehensive hospital-based waiting lists of a kind which are typical in the United Kingdom, for example.

I have provided you with copies of this year's survey from the Fraser Institute. There are many interesting aspects of the study, but two seem to be of particular relevance to your deliberations.

The first is that it is a misnomer to refer to "the Canadian health care system" as though it were one uniform system providing similar service for all Canadians. In fact, access to the health care system varies dramatically depending on where in the country one encounters it.

As chart I shows—and for those of you who have copies of it, I would ask you to look at chart I—and as that chart shows, average total waiting time from referral by the general practitioner to treatment ranges from 11 weeks in Ontario to 21 weeks in Prince Edward Island.

Wait times also vary within Provinces among specialties. In Ontario, for example, wait times varied from 3.7 weeks for urology to 12.6 weeks for ophthalmology.

The fact that Ontario has generally the shortest waiting lists may be of particular interest to the committee, owing to the fact that Ontario was the only province studied when the U.S. General Accounting Office did a ministudy of waiting lists a few years ago. Ontario is not typical, as our survey clearly shows. So any implications or any inferences that the GAO or your committee or anybody else might draw from looking at Ontario is clearly not giving you a good impression of what is happening in the country overall.

The second interesting aspect of the survey relating to the first is the apparent correlation between the waiting time for treatment and the amount which the various Provinces spend on health care. This is evident from Chart II.

As can be seen there, there are two groupings of waiting times, and these are roughly aligned with the amount that each of the Provinces spends per capita on health care. Provinces that spend more per capita on health care have shorter waiting times on average than those that spend less. Ontario, which spent the most, has the shortest waiting time, while Prince Edward Island, which spent the least, has the longest waiting times.

Evidently this point is of some significance when Americans look to Canada for guidance in revising their health care arrangements. What the Canadian experience seems to suggest is that centralized control of health care spending can indeed limit the total amount that is spent. However, with rising levels of demand, the inevitable consequence is the rationing of care, and the tighter the spending control, the more rationing will result and the longer will people have to wait for care.

Recent fiscal developments in Canada suggest that waiting times are likely to increase in the future. All Provinces and the Federal Government are experiencing very large deficits. One of the consequences is that the funding of health care is being reduced at a time when demographic pressures are increasing the demand for health care. The inevitable consequence will be increases in the extent of rationing.

In other words, as Americans look north to Canada, they have to decide whether they want a health care system like that in Ontario with its 11-week waits or that in Prince Edward Island with its 21-week waits. If they do not like the idea of 11-week waits, then they should avoid budget capping as an approach to health care. And since budget capping is the silver bullet or the cost control that is built into all of the major proposals which currently have been made for the revision of your health care system and certainly are an integral part of a single-payer system, I heartily recommend that you look carefully at this Canadian experience before you proceed.

Thank you very much for the opportunity to make this presentation to you.

[The prepared statement and attachments follow:]

THE FRASER INSTITUTE

I appreciate the opportunity to appear before your Committee to bring you the results of The Fraser Institute's latest survey of hospital waiting lists. The Fraser Institute is a federally chartered non-profit research organization which conducts studies of public policy issues. The Institute has published three book-length studies that examine Canada's health care system from different points of view. The latest study, *Caring for Profit*, was conducted by Professor Malcolm Brown, a self-professed advocate of Canada's approach to single payer health care.

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While a survey of specialists may be the only practical way to determine specialist waiting times, it is not the preferred way to measure hospital waiting lists. The Institute adopted this survey approach only after ascertaining that hospitals do not have the information required to build a comprehensive waiting list. The publication of our surveys for the last several years has stimulated considerable interest in the area and I am hopeful that within several years, provincial governments will publish comprehensive hospital-based waiting lists of a kind which are typical in the United Kingdom, for example.

I have provided you with copies of this year's survey. There are many interesting aspects of the study but two seem to be of particular relevance to your deliberations. The first is that it is a misnomer to refer to the Canadian health care system as though it were one uniform system providing similar service for all Canadians. In fact, access to the health care system varies dramatically depending where in the country one encounters it.

As Chart 1 shows, average total waiting time from referral by the general practitioner to treatment ranges from eleven weeks in Ontario to 21 weeks in Prince Edward Island. Wait times also vary within provinces amongst specialties.

In Ontario, for example, wait times varied from 3.7 weeks for urology to 12.6 weeks for ophthalmology. The fact that Ontario has, generally, the shortest waiting lists may be of particular interest to the Committee owing to the fact that Ontario was the only province studied when your General Accounting Office did a mini-study of waiting lists a few years ago. Ontario is not typical as our survey clearly shows.

The second interesting aspect of the survey, related to the first, is the apparent correlation between the waiting time for treatment and the amount which the various provinces spend on health care. This is evident from Chart 2.

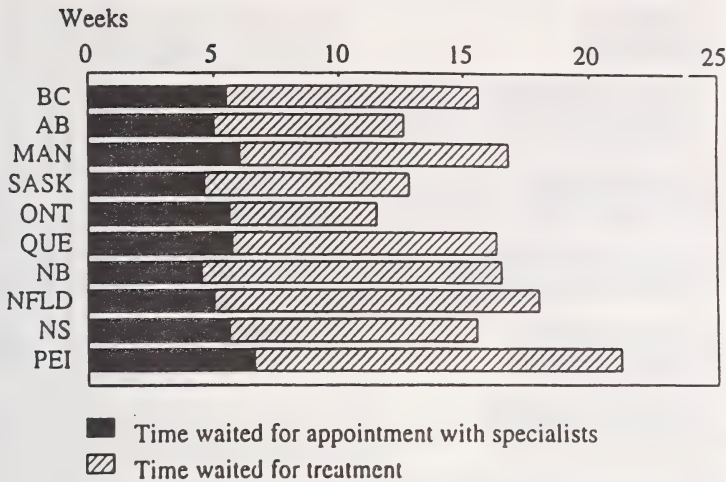
As can be seen, there are two groupings of waiting times and these are roughly aligned with the amount that each of the provinces spends per capita on health care. Provinces that spend more per capita on health care have shorter waiting times, on average, than those that spend less. Ontario, which spent the most, has the shortest waiting time, while Prince Edward Island, which spent the least, has the longest.

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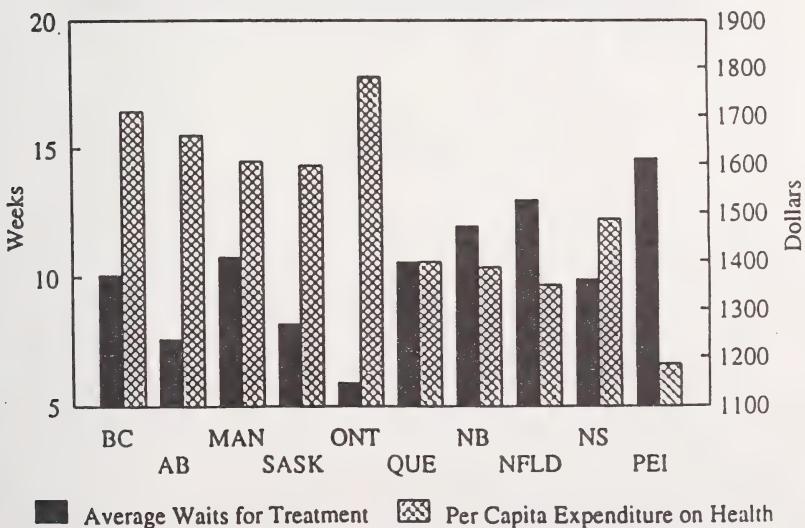
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Chart 1:
Total Waiting by Province
(Time from G.P. Referral to Treatment)



Source: Fraser Institute survey of specialists' waiting lists..

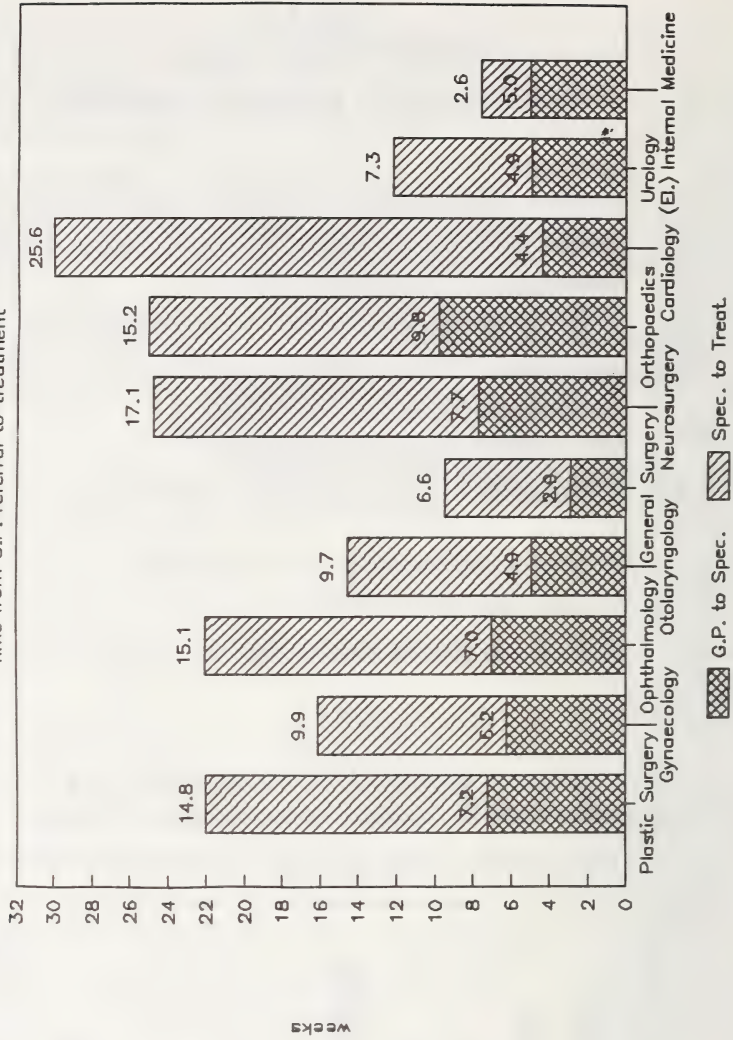
Chart 2: Provincial Government Spending
on Health Care Per Capita Versus Hospital Waiting Lists
(Time between booking of treatment and treatment)



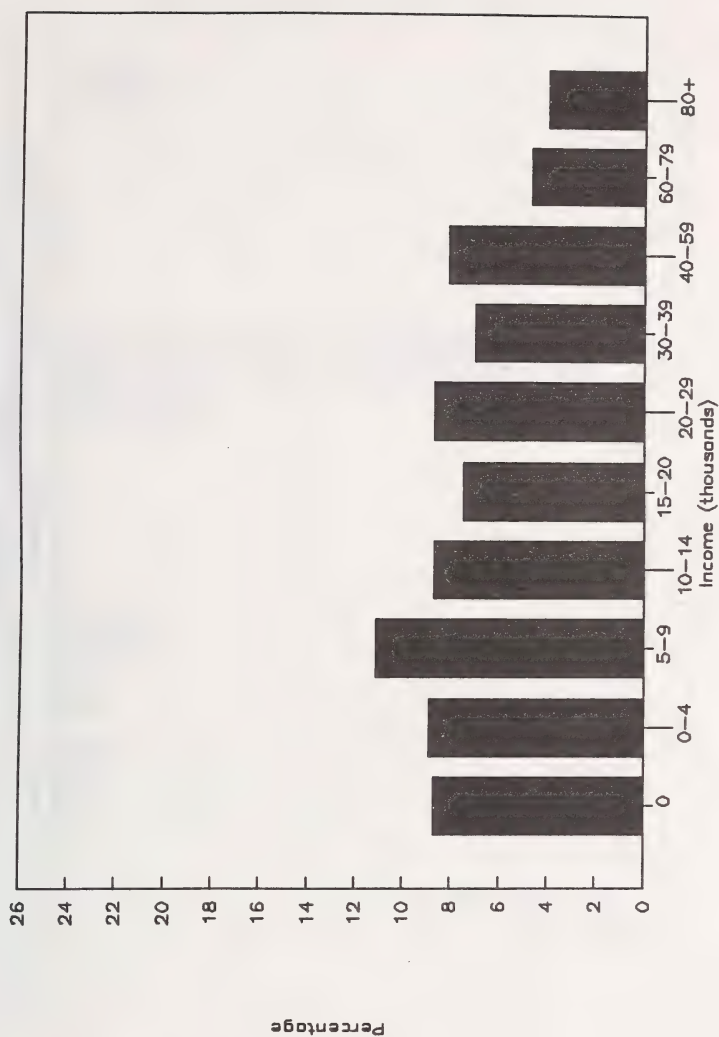
Source: Per capita health care expenditure from "Public Finance Historical Data, 1965/66 - 1991/92," Statistics Canada (cat. 68-512).

Total Waiting by Specialty for Canada

Time from G.P. referral to treatment

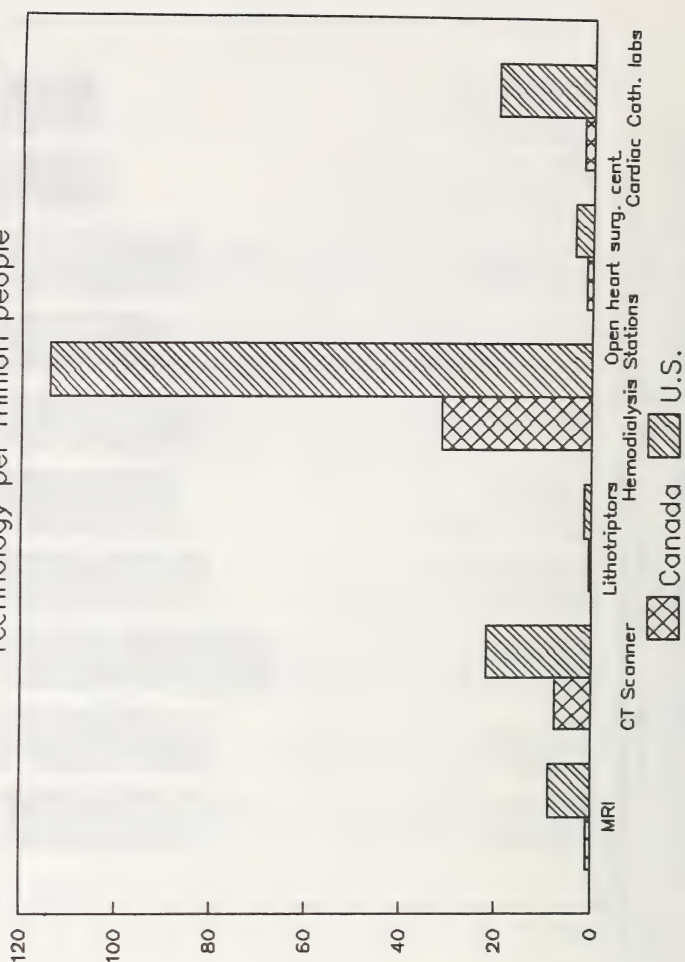


Probability of Waiting by Income Group

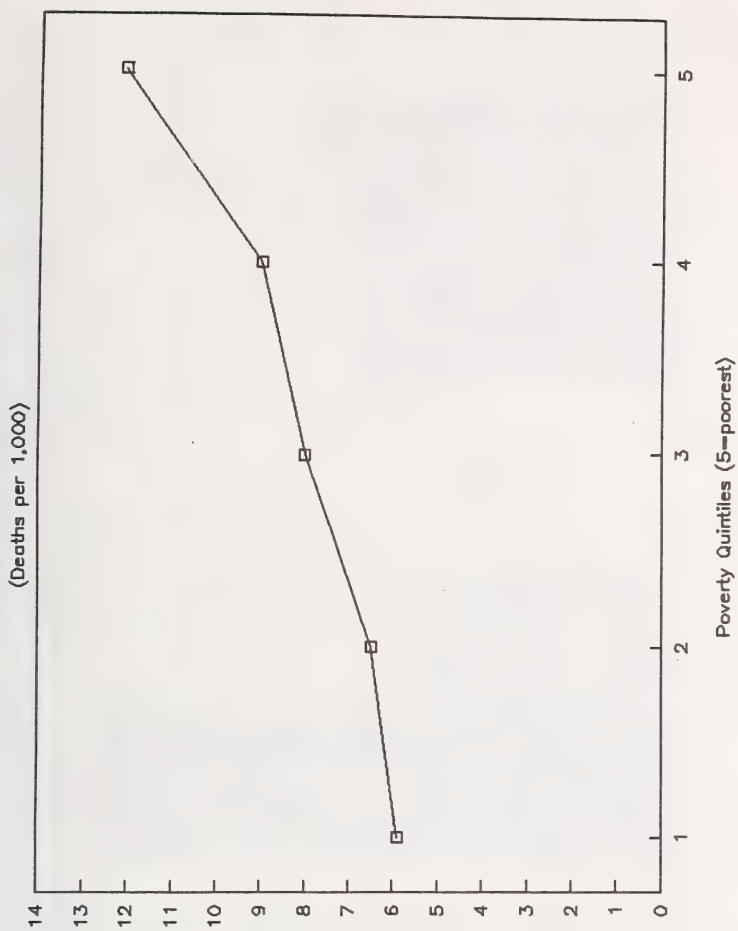


Technology Comparison

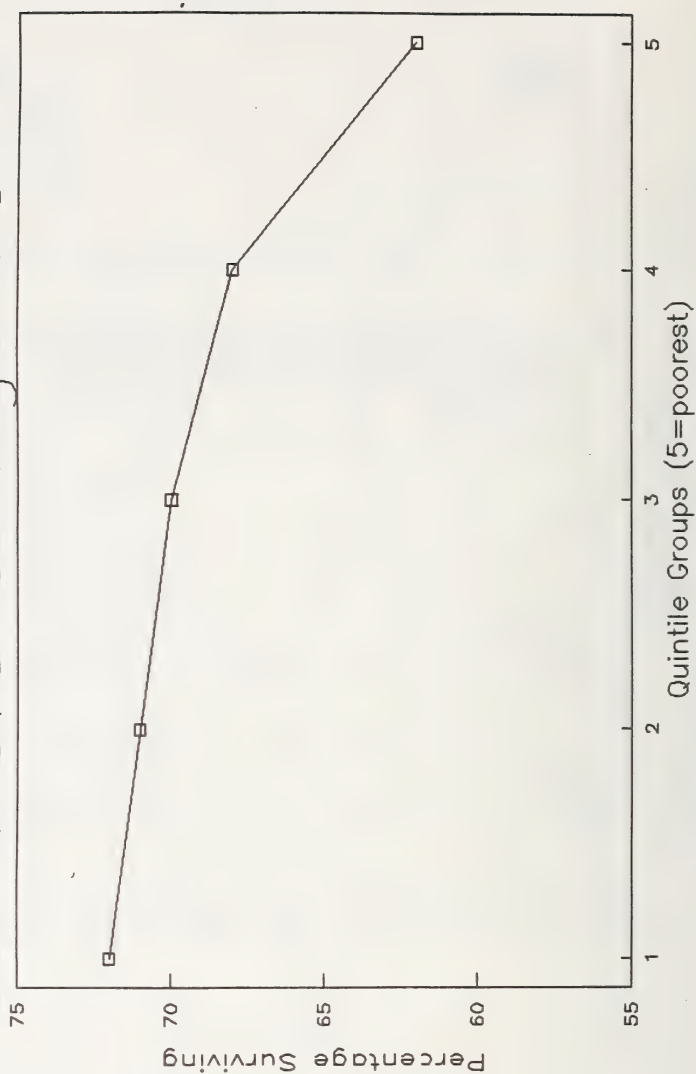
Technology per million people



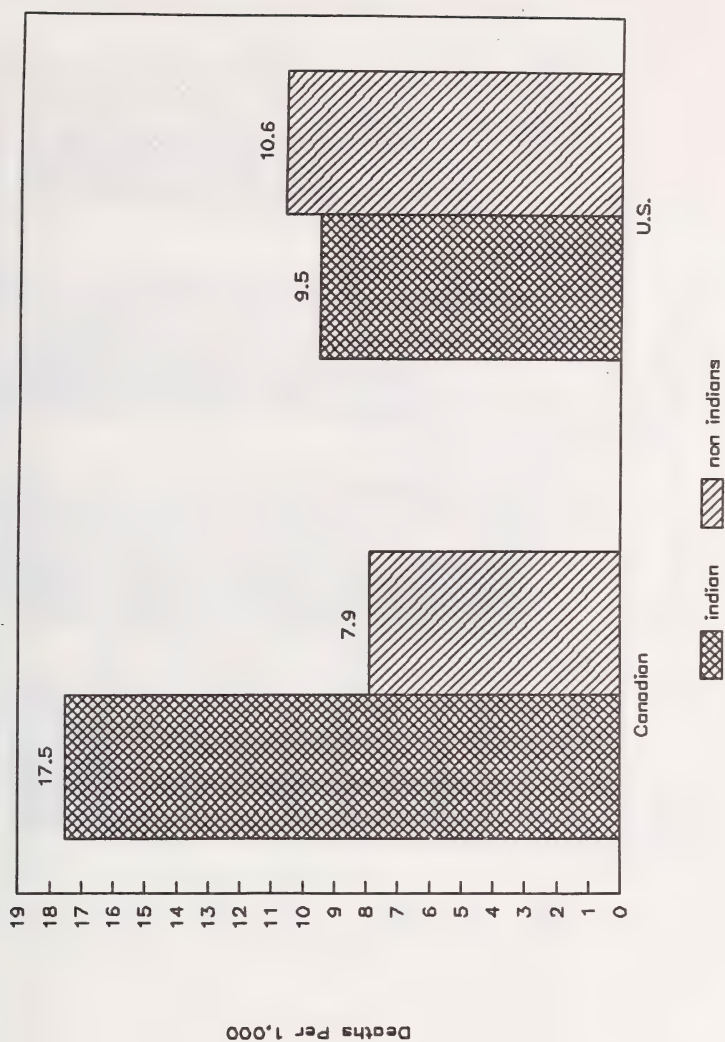
Infant Mortality Rate in Van. & Vic.



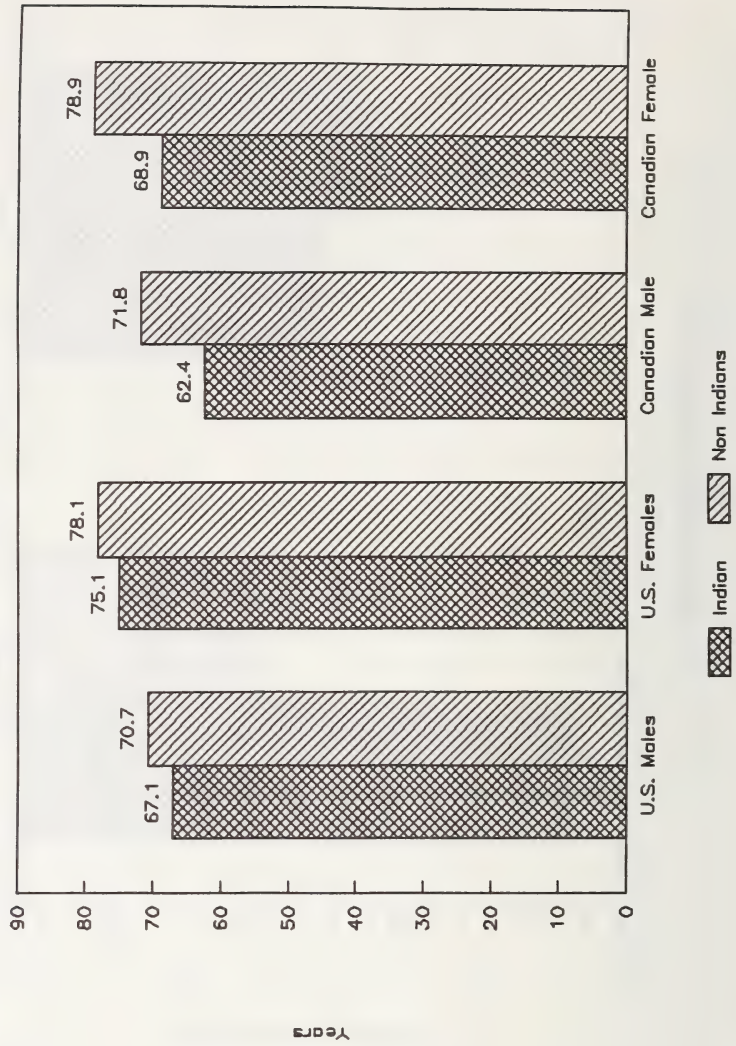
Survivors to Age 75



Infant Mortality



Life Expectancy at Birth



Comparison Between Surgery Rates Surgery per 100,000 population

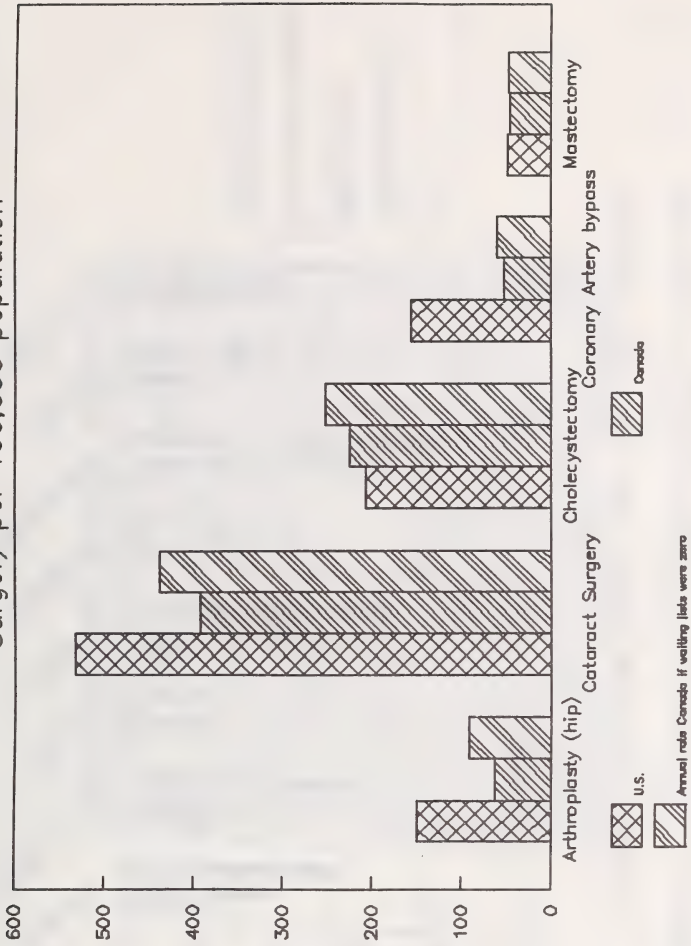


Figure 1. Hip & Knee Replacements in Canada
Age-Adjusted Rates per 100,000, 1989/90

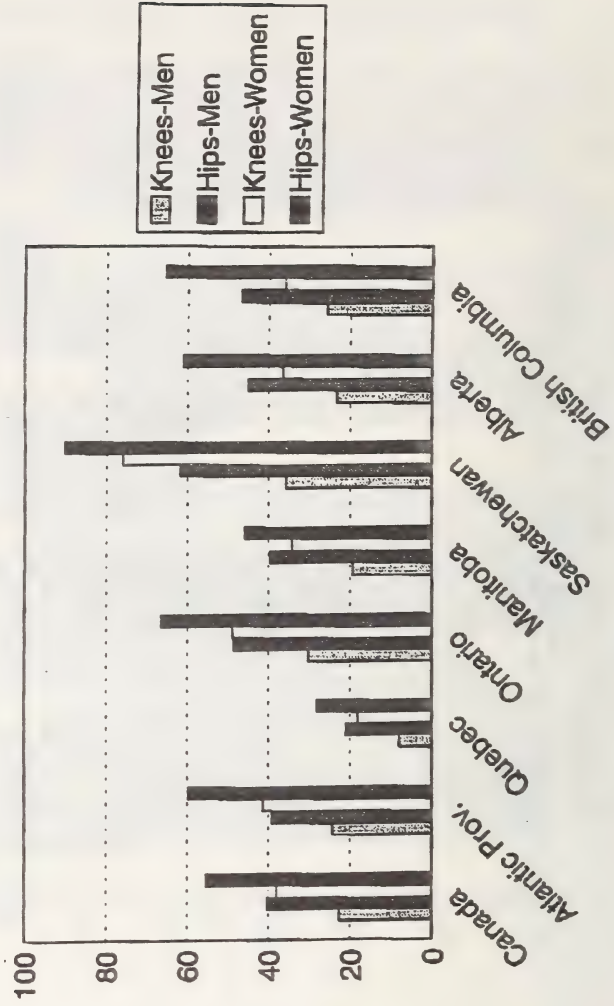


Figure 2. Months Waiting for Surgery by Level of Pain

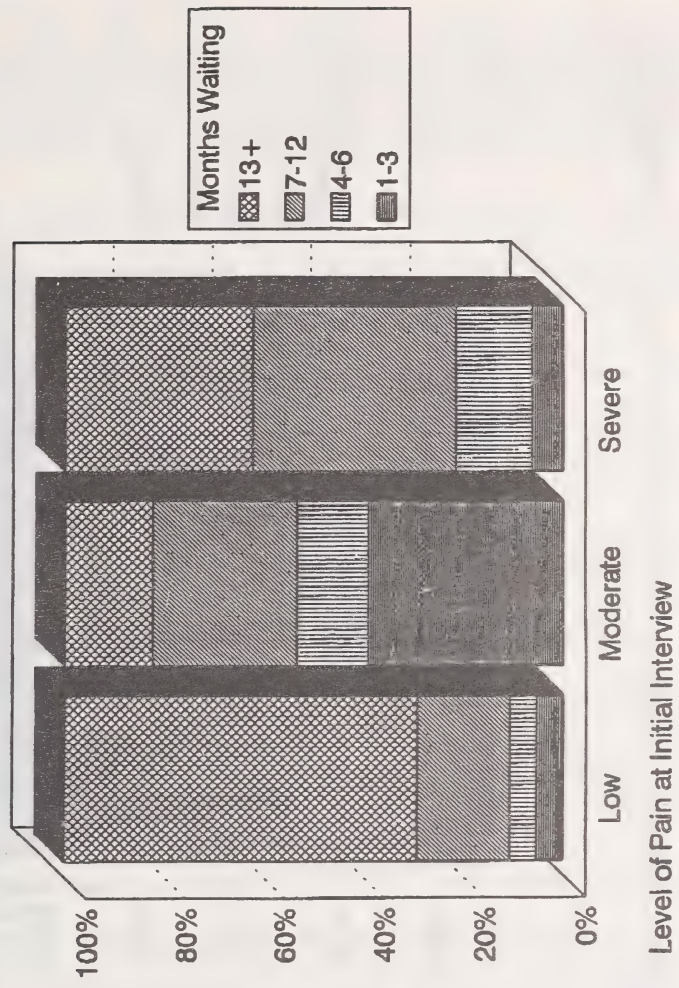
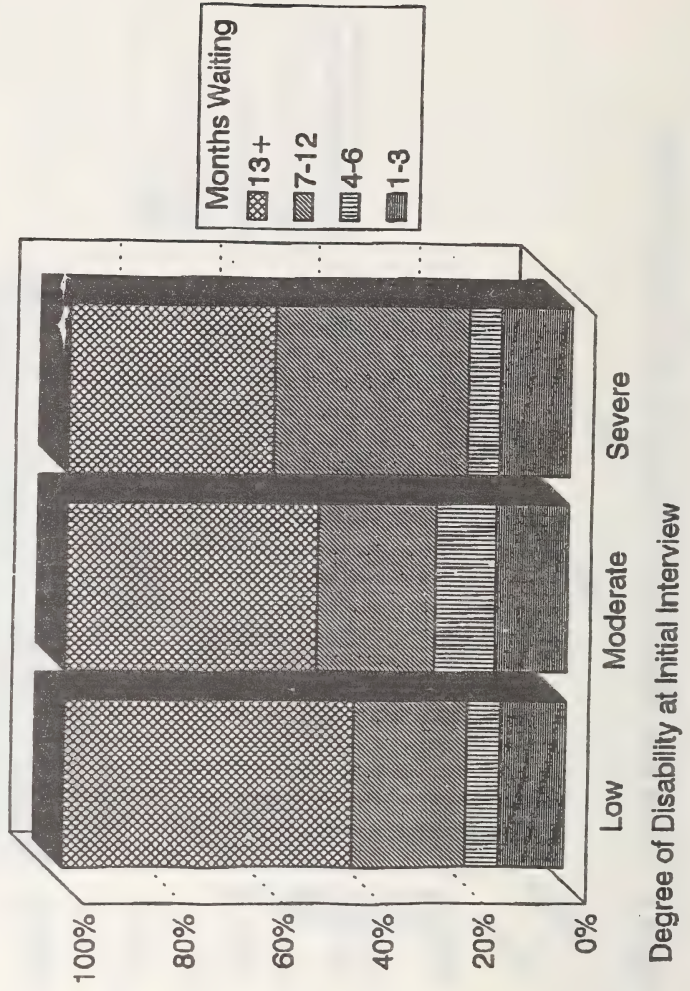


Figure 3. Months Waiting for Surgery by Degree of Disability



Chairman STARK. Thank you very much.

Dr. MacKillop.

STATEMENT OF WILLIAM J. MACKILLOP, M.D., HEAD OF RADIATION ONCOLOGY, KINGSTON REGIONAL CANCER CENTER, ONTARIO CANCER TREATMENT AND RESEARCH FOUNDATION, AND DIRECTOR OF THE RADIATION ONCOLOGY RESEARCH UNIT, QUEEN'S UNIVERSITY, KINGSTON, ONTARIO, CANADA

Dr. MACKILLOP. Mr. Chairman, thank you for the opportunity to tell you about how we provide care for cancer patients in Canada.

I am a radiation oncologist; that is a cancer specialist who uses radiation to treat cancer, and I practice in the city of Kingston in the Canadian Province of Ontario.

Radiotherapy is an important form of cancer treatment. It cures some patients and provides valuable pain relief for others who cannot be cured.

To do its job of killing cancer cells, radiation has to be focused precisely on the cancer, which is often deep in the patient's body. It takes a great deal of skill and care to make sure that we hit the cancer without damaging the normal tissues around it.

Safe, effective radiotherapy relies heavily on complex, expensive equipment and requires a team of highly-trained physicians, physicists, and technologists.

Fifty years ago, the Government of Ontario recognized the enormous value of radiotherapy and created a cancer foundation to make radiation treatment available to all Ontarians.

The decision was made to focus the expensive equipment and expert staff in a few strategically located cancer clinics, which would provide high-quality care for everyone in the surrounding region. Over the years, these clinics expanded their role by adding programs of surgery and chemotherapy, and each of the centers developed its own research program.

This created a publicly-funded, Provincewide network of comprehensive cancer clinics which now provide care to all the residents of Ontario.

All of the staff, including the doctors, are effectively salaried, and all the operating funds for the regional centers come from the Ontario Cancer Foundation, which in return receives its money directly from the Provincial Health Ministry. All services to patients are provided without direct charge. Most of the Canadian Provinces now have similar cancer foundations.

Let me tell you about the strengths of the system. There are no financial barriers to access, and the cost to the patient is not, therefore, a consideration in the choice of treatment.

The system is highly efficient. We do not have duplication of expensive facilities, and all components work at close to full capacity. People like me do not do any paperwork that is not directly related to patient care. Doctors are allowed to get on with the business of looking after patients.

We provide high-quality patient care, and the equitable distribution of resources by the Cancer Foundation means that similar services are available right across the Province. Our large centers concentrate a tremendous amount of specialized skill and experi-

ence in one place. Radiation oncologists work in group practices, and this gives us the opportunity to develop special expertise in specific types of cancer. We work in teams with medical oncologists and surgeons, and we usually manage not to be competitive with each other.

This system of ours in which all doctors have hard ceilings on their incomes and in which they work closely with one another is probably responsible for the relatively conservative Canadian approach to cancer treatment.

We have found, for example, that Canadian doctors who treat larynx cancer, including the surgeons, are far more likely to recommend radiotherapy to conserve the voice box than their American colleagues.

We have also found that Canadian doctors are less likely than Americans to recommend radiotherapy or chemotherapy for patients with advanced and incurable lung cancer and are much more likely to recommend supportive care instead of active treatment.

Despite its many advantages, our system is far from perfect. Many patients have to travel long distances for radiotherapy. To some extent, this is inevitable in this vast country of ours, but in planning the distribution of cancer centers, concerns about quality of care and efficiency have taken priority over concerns about convenience.

There are now long waiting lists for radiation treatment at many cancer centers in Canada. This was unheard of a decade ago, but the incidence of cancer has doubled in the last 20 years, and unfortunately the cancer system has not expanded fast enough to keep up with the increase in demand for radiation treatment. This is a matter of great concern to us.

The message for you, I think, is that managed systems must be well-managed, or they may become a liability.

Mr. Chairman, I have described some of the strengths and weaknesses of the Ontario cancer system, which operates on the single-payer model. In general, Canadians seem well satisfied with the service we have provided over the years. The cancer center in which I work provides care for more than 2,000 new patients each year, but it has not been faced with one malpractice suit against any member of its medical staff since it was established in 1947.

Our system has much to recommend it in spite of its recent difficulties.

Thank you, Mr. Chairman.

[The prepared statement and attachment follow:]

STATEMENT OF DR. WILLIAM J. MACKILLOP, HEAD OF RADIATION ONCOLOGY, KINGSTON REGIONAL CANCER CENTRE, ONTARIO CANCER TREATMENT AND RESEARCH FOUNDATION, AND DIRECTOR OF THE RADIATION ONCOLOGY RESEARCH UNIT, QUEEN'S UNIVERSITY, KINGSTON, ONTARIO, CANADA.

Mr. Chairman and members. Thank you for the opportunity to tell you about how we provide care for cancer patients in Canada.

I am Dr. William Mackillop. I am a Radiation Oncologist, that's a medical specialist who uses radiation to treat cancer, and I work for the Ontario Cancer Foundation in the city of Kingston in the Canadian province of Ontario. Let me begin by giving you a few words of background about radiation treatment, and then I will outline for you what I see as the strengths and weaknesses of our system.

RADIATION ONCOLOGY IN CANADA

Radiotherapy is an important form of treatment for cancer. It can cure some diseases like cancer of the cervix even when patients are beyond hope of cure by surgery. In other diseases it is a useful alternative to a surgical procedure which would leave the patient with a permanent disability: cancer of the larynx, for example, can be cured by surgery or radiation, but the surgical option may mean that the patient will lose his ability to speak. Radiation is also very effective in relieving pain in patients with advanced and incurable cancer. While radiation is certainly not useful in every case, it plays an important role in the care of about 50% of all patients.

To do its job of killing cancer cells, radiation has to be focussed precisely on the cancer which is often deep in the patient's body. It takes a great deal of careful planning with sophisticated equipment to make sure that we hit the cancer without damaging the normal tissues around it. The radiation treatment itself is usually given by skilled radiation therapists using large modern x-ray machines. The whole process relies heavily on complex, expensive equipment and requires the support of a team of highly trained physicians, physicists and technologists.

Fifty years ago, Ontario recognized the enormous value of radiation treatment, and created a Cancer Foundation to make radiation treatment available to everyone in the province. The decision was made to focus the expensive equipment and expert staff in a few strategically located cancer clinics which would provide high quality radiation therapy for everyone in the surrounding region. Over the years these clinics expanded their role by adding programs of surgery and chemotherapy, and each of the centres developed its own research interest. This created a publicly funded, province wide network of comprehensive cancer centres which now provide care to all the residents of Ontario who require cancer treatment. In Ontario, which is twice the size of Texas, we have just nine cancer centres. All the staff, including the doctors, are effectively salaried, and almost all the operating funds for the regional centres come from the Ontario Cancer Foundation, which in turn receives its money directly from the provincial health ministry. All services to patients are provided without direct charge.

Most other Canadian provinces now have similar cancer foundations.

THE STRENGTHS OF THE SYSTEM

I would like to tell you about the strengths of the system.

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3) We provide high quality patient care, and the equitable distribution of resources by the Cancer Foundation means that similar services are available right across the province. Our large centres concentrate a tremendous amount of specialized skill and experience in one place. Radiation oncologists work in large group practices, and this gives us the opportunity to develop special expertise in specific types of cancer. We work in teams with medical oncologists, and surgeons, and we usually manage not to be competitive with each other.

4) This system of ours, in which all doctors have hard ceilings imposed on their incomes, and in which they work closely with one another, is probably responsible for the relatively conservative Canadian approach to cancer treatment. We have found, for example, that Canadian doctors who treat larynx cancer, including surgeons, are far more likely to recommend radiotherapy to conserve the voice box than their American colleagues (Figure 1). We have also found that Canadian doctors are less likely than Americans to recommend radiotherapy or chemotherapy for patients with advanced lung cancer, and more likely to recommend supportive care instead of active treatment (Figure 2).

THE WEAKNESSES OF THE SYSTEM

Despite its many advantages, our system is far from perfect.

1) Many patients have to travel long distances for radiotherapy. To some extent, this is inevitable in our vast country, but in planning the distribution of cancer centres, concerns about quality of care and efficiency have taken priority over concerns about convenience.

2) There are now waiting lists for radiation treatment at many cancer centres in Canada. This was unheard of a decade ago. Our population is aging, and cancer is a disease of the older person: As a result, the incidence of cancer in Canada doubled in the last twenty years and, unfortunately, the cancer system did not expand fast enough to keep up with the demand for radiation treatment. This is a matter of great concern.

We radiation oncologists are responding by looking closely at the way that we treat patients. Just as in other areas of medicine, there are variations in the way doctors use radiotherapy and we are seeking to find the most effective and efficient ways of using the resources available to us today. Governments across Canada are also responding by expanding facilities and training more staff, but it will take some time before the supply of radiation treatment will catch up with demand. In retrospect, it is clear that we did not monitor the situation as closely as we should have, and that we did not respond rapidly enough to early signs of strain in the system. The message for you is that managed systems must be well managed.

CONCLUSION

Mr. Chairman, I have described some of the strengths and weaknesses of the Ontario cancer system, which operates on the single payer model. In general, Canadians seem well satisfied with the service we have provided over the years. The cancer centre in which I work provides care for more than 2,000 new patients per year but it has not been faced with one malpractice suit against any member of its medical staff since it was established in 1947. In spite of its recent difficulties, our system has much to recommend it. I would be pleased to answer any questions that you may have about it.

Proportion of Doctors Who Recommended Radiation
for Moderately Advanced Cancer of The Larynx
(T₃,N₀,M₀, Glottic)

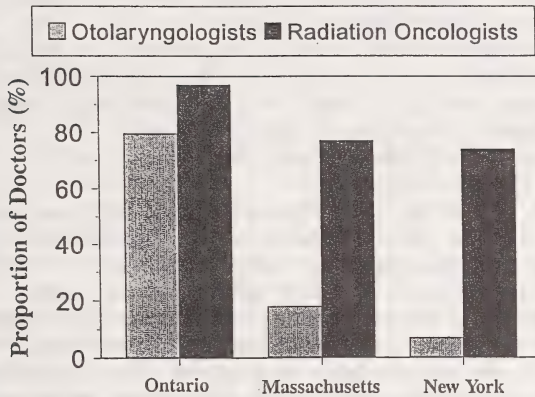


Figure 1

From O'Sullivan, Mackillop, et al, Radiotherapy and Oncology, 1994.

Treatment Recommended for Patients with Advanced
Lung Cancer (Stage III_b, Squamous Carcinoma)

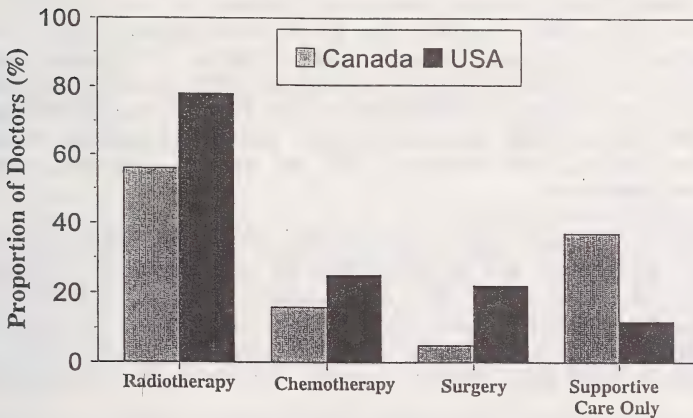


Figure 2

From Palmer and Mackillop, Radiotherapy and Oncology, 1990.

Chairman STARK. Thank you.

Mr. Smedley, perhaps you could define for me, on page 4 you suggested only 40 percent of the 10 million pre-Medicare retirees have any—and I am quoting—"business-provided health insurance." How do you define "business-provided health insurance"?

Mr. SMEDLEY. It was written by staff, Mr. Chairman. I would assume that would be a private business.

Chairman STARK. Well, I would hope that you could review that. Our figures show—and I am sure the ones that CBO is using—that only 25 percent are uninsured, which would mean that 75 percent have some health insurance as early retirees.

Mr. SMEDLEY. I will check that, Mr. Chairman.

Chairman STARK. Please do.

Mr. SMEDLEY. I think your figure sounds very, very—

Chairman STARK. Well, whatever the figures may be, if I take yours, you are suggesting that those 40 percent or 4 million people should have, in effect, Uncle Sam pick up their costs.

Now that is an interesting idea, but it costs \$8 billion a year, and the major corporations are committed to paying that.

What rationale do you have to suggest that for those 40 percent who have business-provided health insurance, what earthly reason is there to let General Motors and General Electric off the hook and ask the rest of the taxpayers to kick in \$8 billion a year?

Mr. SMEDLEY. I will be happy to answer the question, Mr. Chairman.

First on the question of the differential in figures, it may be that the 75 percent comes—that many of those people buy their own health insurance.

Chairman STARK. That may well be. But I am just taking your figures.

Mr. SMEDLEY. It is not—this is business-provided.

Chairman STARK. Let us take your figures.

Mr. SMEDLEY. That is where the 40 percent comes from.

Chairman STARK. Let us take your figures. Of the 40 percent with business-provided health insurance, why should we pick up what is now arguably an obligation of the companies, \$8 billion?

Mr. SMEDLEY. Well, let us—in any universal system, which I think you strongly advocate as well as we do, that you want to cover everybody—

Chairman STARK. I do.

Mr. SMEDLEY. Now we have had the precedent when the Medicare law, which you are so interested in expanding, if I remember correctly, we passed that law, and because some of the employers were covering retirees with health insurance, you did not make them continue to cover costs that Medicare covered. That is a precedent, a very good past precedent, which could be carried forward.

If some employers cover their employees with retiree insurance—they have been more socially conscious or perhaps through a collective bargaining agreement—but other employers simply dump their employees on the national health care system—

Chairman STARK. I agree.

Mr. SMEDLEY. Why should we have the differential treatment? Why should we treat—

Chairman STARK. Well, I agree with you, but——

Mr. SMEDLEY. Why should General Motors not be a better employer?

Chairman STARK. Why should they not get into the universal plan? Why do we single out these people to get a special plan that other people would not get.

I am with you. Fine, put them into whatever the national plan is. I am with that. But I would think one would require a maintenance of companies, but if we do not, I see no reason to take this little group and give them a special deal.

I agree with you that everybody should have coverage. If they lose their job, they lose their job; they get coverage.

You may not have figured out, but I would ask you to have your staff reread the President's bill. Any one of these early retirees who happens to have a spouse who is working anyplace else where they offer health insurance would not qualify for Medicare. As a practical matter, there are some of us who might live to be 100 before our spouses would be old enough for us to get Medicare—absolute lunacy in terms of destroying Medicare.

Further, if you like Medicare and if you research the President's system, you will see that in the President's plan is a formula to destroy Medicare, to deplete the resources of its trust fund far more rapidly than they are now and, in fact, to offer financial incentives to people not to join, particularly young people coming onto Medicare.

If you wanted to privatize Medicare tomorrow, with these two combinations, you could not figure out a better way to disband the system. And I would urge those of you who, I think, blindly accept the President's plan, to read it a second time. There are those of us who do share your goals, but who question this plan that was conceived in secret over the past year, without the input of either the UAW or any decent union and without the input of Congress or without the input of all but one or two Jackson Hole—trained health experts. It is somewhat disconcerting to see people who ought to be on the right side of social issues buying into a pig in a poke.

And I commend you to return to your staff and ask them to please reconsider.

Mr. Thomas.

Mr. SMEDLEY. I will do that, Mr. Chairman. We will look at the President's bill, read it very carefully a second or third time, and I would say that as long as we have the same goals, knowing that you are a reasonable man, I am sure that we can come to some reasonable solution to the problem to deal with the early retirees, of which we have a large number in our membership, to deal with them fairly.

Chairman STARK. I understand that. Thank you.

Mr. THOMAS. Thank you, Mr. Chairman. I commend the chairman's statement. Folks who preach ought to walk a mile in somebody else's shoes.

Chairman STARK. Just give me your proxy.

Mr. THOMAS. No, I do not give you my proxy. I just praise you, that is all. Praise is cheap; proxies are expensive.

I apologize to the panel. We were over voting. There was a mixup with the voting panel, and one of my secondary responsibilities is running the shop a little bit, and so we were trying to work on the computer glitch that would not allow the members to see their vote. They recorded their vote, but they were not allowed to see it.

I want to talk to the Canadian doctors only, because I am not familiar with the Canadian system as I would like to be, and I assume you are probably far more familiar with our system, so that if I asked you some comparative questions, you would be better able to make the comparison than would I, based on my knowledge, and try to quiz it.

And, of course, one of the concerns we have is the cost controls, and we are toying with various mechanisms to determine how we can control costs. One one of the things that I was concerned about with the single-payer model is that you either have the benefit package drive the costs, or you limit the costs, and that determines the benefit package.

And I guess, Dr. Walker, we can get into this by saying: From your history and perspective on Canada, when you cap budgets, how does it most often manifest itself in the Canadian structure?

Mr. WALKER. Well, first of all, the budget caps are, themselves, manifested in four different ways. There are caps on the hospital care system and the physician care system. The hospital care system is capped in three different ways.

Hospitals typically get an operating budget. They get a separate budget for special surgeries, and they get a separate and third budget for the acquisition of capital. So from a hospital's point of view, the capping of their expenditures can be therefore manifest in three different consequences. Either they have to curtail their general operations; they have to curtail specific operations; or they have to curtail acquisition of technology when the budgets are insufficient to cover all of their costs.

The fourth budget cap, of course, is on physicians' fees.

Mr. THOMAS. Historically has it not been a prioritization or a hierarchical ranking of those most often? It would seem to me that instead of cutting into ongoing structured arrangements, the technology would be an easy one to forego.

Mr. WALKER. Well, I guess one thing that is evident from the data—and I think you would find this from talking to professionals—is that there does not seem to be any sort of coherent approach. Choices are made in the content of the political system. And if there is more political pressure, as you heard from somebody in the first panel, if there is a shortage of bypass surgeries and there are stories in the newspapers about that, then the politicians respond by getting the bureaucrats to allocate more money in that area and so on.

Mr. THOMAS. OK.

Mr. WALKER. So it really is——

Mr. THOMAS. It depends.

Mr. WALKER. It depends.

Mr. THOMAS. Like the way we do liver transplants here. If you can get in the newspaper or on the media, you have a chance of getting one. And if you do not, you do not.

Mr. WALKER. There is, however, a very, I think, special effect here on technology acquisition, because in the process of making their cost allocations, Governments in Canada do say things like: Well, is the technology proven? You know, are we sure that this is a cost-effective procedure? Are we sure that it is medically effective and so on?

And so there is a kind of wait-and-see attitude built into the Canadian system, and typically, of course, as you may imagine, what we are waiting to see is how it works out in the United States. In other words, we do not acquire technologies very often until they have been proven to be clinically and cost effective in the United States first.

Mr. THOMAS. Well, we are finding out that that is part of the problem in pharmaceuticals. We are the only ones who are on the cutting edge. And I guess if you are in a race and there is somebody in front of you, you can pace yourself to try to get in front of them.

But for so many areas, we are running against the clock, and the question is whether or not you are going to continue the commitment to excellence, regardless of any kind of a comparative arrangement.

And if we fall under the same system, maybe each other is watching each other to see who goes first, it is Alphonse/Gaston, and nobody goes through the door, and I think then that clearly indicates that you get a quality reduction that would otherwise be present, and as you indicated oftentimes with the choices that are made by administrators or politicians, one of them, I assume, would be inevitably waiting to get some kind of an elective procedure, as we heard. Waiting is rationing in whatever form you want to look at it.

Just briefly to Dr. MacKillop, if I might, Mr. Chairman, obviously there is more and more emphasis on this whole question of cancer and cancer treatment. I noticed the headline on the USA Today newspaper was "The Boomers Cancer Risk Tops Grandparents." It is moving in on heart disease. The question of how you treat cancer, early detection, radiation, chemotherapy, surgery.

In your analysis of the United States versus Canada, clearly there may be preferences for particular choices, but in your experience, are there any choices that seem to be dictated by the structure rather than either by the physician's first choice or what might be best for the patient, which I think is probably the most damaging thing that anybody can say about a structure?

Are you familiar with any structural definitions of what you do, rather than—

Dr. MACKILLOP. I can only speak from personal experience and from two surveys that we have carried out that have compared practice in Canada and the United States.

The first is in a disease which is cured by radiotherapy or surgery, carcinoma of the larynx. And we have asked practitioners in the United States and Canada and across the English-speaking world about what choices they make and what recommendations they make for their patients. And we have observed that practitioners in the United States much more frequently elect an operative

procedure that involves sacrifice of the larynx and natural speech than practitioners in Canada.

It is not, I think, a matter of certainty why that arises, but I think in Canada decisions are made by teams of practitioners who have no financial interest whatsoever in the medical decision that is made.

My sense is that a system in which doctors' incomes do not depend on the level of their technical activity allows them to exercise their clinical judgment without some of the restraints that are inherent in your system, and it produces different practice.

In patients with incurable cancers, I think Canadians are also more conservative in their recommendations for patients than Americans. And to some extent, I think that that has been conditioned by your public rather than by your medical profession.

It seems to us that Americans are willing to accept any risk for the most meager of benefits for treatment of a cancer. We know that in your society third, fourth, and fifth line chemotherapy for patients with breast cancer is essentially standard treatment and has become part of the sad ritual of dying from this disease in the unfortunate women who cannot be cured of it.

There is no evidence from any outcome study or from any randomized clinical trial that third, fourth, or fifth line chemotherapy offers any benefit either in terms of survival or in terms of quality of life above a policy of supportive care.

I understand that to some extent fear of legal action for doing anything less than the maximum drives some of our colleagues in the United States to do more than they really judge to be appropriate.

Mr. THOMAS. Well, I guess the easiest way to determine where you would go, given your knowledge and expertise, is to say that if you are where you are now, and you had a colleague diagnose you in terms of some kind of cancerous situation, say the larynx or in the throat or in the neck, would you stay in Canada to be operated on, or would you go someplace else?

Dr. MACKILLOP. If I could have prompt care in Canada, I would be very comfortable with the services offered by our system.

I happen to work in a community in eastern Ontario where we are not greatly constrained in our choices by a shortage of supply of either operating room time or radiotherapy time.

In metropolitan Toronto, in our biggest city, the delays which are imposed on some patients before they can start radiation treatment would make me think twice, I think, about whether I would be willing to wait for several weeks before starting radiotherapy treatment. And clearly as someone in the profession and with a significant income, I could buy myself around that problem by seeking care in the United States if that situation arose.

I should emphasize that this is a relatively recent problem in my own particular discipline of radiation oncology, and I do not think it arises through capped budgets, but through very poor forward planning.

Mr. THOMAS. My concern is the growing need, not just for elective procedures, but need in terms of the cancer area.

Finally you indicated with some sense of pride—and in this country, it would be miracle, not just pride—that you have never been

sued for malpractice. I have got to believe that there is some kind of a different structure that we are dealing with Canada in terms of malpractice; one, in terms of the attitude of people toward others in terms of suing, and second, what you can get out of suing and your chances of winning in the system.

I would think that perhaps some of the practices that you outlined that were not practiced in Canada would, in part, be because of the fact that there was very little fear of having a malpractice suit brought against you and the relatively poor chance of success beyond just basic economic damages that would be received, which mean, I guess, if you are nodding your head, that means yes, that you would think that one of the fundamental things that we should do is examine our malpractice structure and make some changes there.

Is that a fair statement?

Dr. MACKILLOP. Well, I think you should perhaps examine your relationship with your patients and find out why they so often seek recourse to this very adversarial form of resolution of dispute. I think it reflects—

Mr. THOMAS. Not just doctors with patients. Anybody with any professional relationship with anybody else in the United States would have to ask themselves that question, because we sue everybody for anything and for nothing.

Ms. NICHOLS. Mr. Thomas, could I add one point to this?

Mr. THOMAS. Sure.

Ms. NICHOLS. Which is just that it is important to note that one of the main reasons that victims of medical negligence in this country turn to the courts for restitution, rather than in Canada, although we do have different legal systems, is because they need coverage of their medical bills.

So under a single-payer system, a universal system, many people might not go to the courts who otherwise do. It is one way of taking care of that problem.

Mrs. JOHNSON. Would the gentleman yield?

Mr. THOMAS. Well, there is a whole downside to that. But I will let my colleague jump in, because I think she wants to take off on that. Go ahead.

Mrs. JOHNSON. I think this is a very important point. And you are right. There is no reason to sue in Canada to get reimbursement for medical costs.

On the other hand, it is also true in Canada that you cannot get reimbursement for pain and suffering and that cases do not go to juries and that you cannot sue on the basis of paying the lawyer later, as you can here.

So our whole system encourages suits, particularly if there is a possibility of an emotionally-based award, and that is a cost driver. I do not think anyone adequately or can honestly estimate the amount of cost associated. But if you talk to people in the business, it certainly has altered the way we practice and how we think about diagnosis and treatment.

But both of the—

Mr. THOMAS. Would the gentlelady yield briefly?

Mrs. JOHNSON. Yes.

Mr. THOMAS. So that I could make a unanimous request of the chairman that this, the Fraser Institute's Forum, which is a bulletin published, I believe, 12 times a year—the 1993 third edition had a Critical Issues Bulletin on "Waiting Your Turn, Hospital Waiting Lists in Canada," and ask unanimous consent to put it in the record, Mr. Chairman.

Chairman STARK. Without objection.

[The preface to the bulletin follows. The entire publication is being retained in the committee files:]

FRASER FORUM

1993

CRITICAL ISSUES BULLETIN I

***Waiting Your Turn:
Hospital Waiting Lists in Canada***

3rd edition

**by Joanna Miyake
and Michael Walker**



Preface

Michael Walker

THE FRASER INSTITUTE HAS long had an interest in the health care system and in providing information about it to those concerned about establishing an appropriate public policy framework for the delivery of this vital service.

The Fraser Institute has published three books dealing with Canada's health care system.¹ While each author approaches the subject from a different perspective and from a different analytical orientation, all are concerned with the impact of economic arrangements regarding health care on the quality and quantity of health care services delivered to Canadians. Our interest was particularly piqued several years ago by my discovery that in the United Kingdom, local governments actually produced publications listing hospital waiting lists for a selection of operations as a guide for health care consumers. The intent in pub-

lishing the lists was to improve the efficiency of the National Health Service by ensuring that health care consumers were aware of the hospitals which had the shortest waiting times. Since the lists were much longer than could be justified by the desire to avoid unused capacity or to permit patients to have enough time to arrange their affairs prior to admittance to hospital, the unavoidable conclusion was that waiting was being used as a method for rationing health care in the U.K.

About the same time, anecdotal evidence began to emerge suggesting that hospital waiting lists were starting to become significant in Canada. However, there were no systematic measurements of the extent of waiting. Those partial waiting list measurements which were made by hospitals and by government departments were regarded as politically sensitive and they

¹ Åke Blomqvist, *The Health Care Business*, 1979; Ronald Hamowy, *Canadian Medicine, A Study in Restricted Entry*, 1984; and Malcolm C. Brown, *Caring for Profit*, 1987.

were not made generally available. Some preliminary measurements made by The Fraser Institute indicated that waiting was much more prevalent in the 1990s than it had been in the late 1960s. At the same time, there was increased concern about the cost to the government of continuing to supply the level of health care services that had been the norm. The health policy issue associated with these two developments is the possibility that waiting lists or queues are being used as an alternative to rising prices; they restrain health care expenses in a system where prices have been systematically eliminated and neither physicians nor patients have the slightest economic incentive to consider the costs of their decisions.

The current *Critical Issues Bulletin* is the Institute's third attempt to document the extent to which queues are being used as a means of adapting to the conflict between limited budgetary allocations and unlimited demand for free health care.

The study, conducted by Joanna Miyake and myself with the assistance of Steven Globberman, has been enthusiastically supported by The Fraser Institute, but the work we have undertaken has been independently conducted. The views expressed in this study, therefore, may or may not conform with the views of the members and Trustees of The Fraser Institute.

The Institute is pleased to offer the results of the research to the public for consideration and debate in the hope that more attention will be focused on the issue of hospital waiting lists and on improving our measurements of and knowledge about this aspect of health care provision in Canada. The fact that the provincial governments across the country are mounting projects to produce "official" hospital waiting lists is a concrete indication that our work has been useful in stimulating appropriate concern about this public policy issue.

Mrs. JOHNSON. Thank you.

Dr. MacKillop and Dr. Walker, both of you have brought some very interesting material before us and have a great deal of research experience to offer as well.

Dr. MacKillop, do you have any specific information about comparative waiting times for radiation treatments in Canada and the United States?

There are a number of questions, so if we could be brief that would be helpful.

Dr. MACKILLOP. I do have such information. We have recently carried out a survey of waiting times, absolute waiting times, in Ontario using the electronic database of the Cancer Foundation, which demonstrated that—and I will take an example of carcinoma of the larynx—that the waiting time for treatment between diagnosis and initiation of treatment with radiotherapy doubled from about 2 weeks in the early 1980s to just over 4 weeks in the beginning of the 1990s.

I have not accessed similar information in the United States, but I have surveyed heads of departments at the 26 radiotherapy centers in Canada and at 75 comparable comprehensive cancer centers in the United States listed by the International Union Against Cancer, the UICC, and our observations confirm what I think we realized on an anecdotal basis, that patients in Canada in general wait longer for radiotherapy than they do in the United States.

Mrs. JOHNSON. Significantly longer?

Dr. MACKILLOP. Significantly longer, such that the waiting times that you have currently in the United States are similar to those that obtained in Ontario at the beginning of the 1980s, such that you start patients on treatment about 10 days—that is the median, the average, the central value—about 10 days after a patient is referred to a Radiation Oncology Department, and in Canada that is 30 days.

And in other diseases such as carcinoma of the prostate, the difference is wider, the median value in the American departments being 2 weeks, and the median value in Canadian departments being 6 weeks.

However, one must recognize that the median is the central value, and that means that in 50 percent of those departments, people wait a shorter time, but in 50 percent they wait a longer time.

All of the differences in five disease sites that we explored are significant and of a similar order of magnitude, a doubling or a three times as long wait in Canada as compared to the United States.

Mrs. JOHNSON. Thank you. I think particularly in radiation therapy, that is a very significant issue that does raise quality issues.

How does the standard of care available to cancer patients in Canada compare today with the situation 5 years ago or 10 years ago? In other words, when you look at the pace or the evolution of care in terms of cancer in Canada—and I think you are probably generally familiar with those issues as well in America—can you make any comment about pace of evolution, base of change in diagnosis and diagnostic and treatment capability?

Dr. MACKILLOP. I cannot comment on the American situation, because I do not have any special expertise.

But the Canadian system has been beleaguered by the lack of resources to provide prompt care. The quality of care, I believe, within our very tightly organized cancer system where all of us work essentially in academic environments, in teaching hospitals associated with universities, I think the quality of care is good. The audits that I have carried out would confirm that, and there is the opportunity for continuous peer review in that environment, and I have great confidence in the quality of care.

Access, I believe, has deteriorated over the last 5 years. Our governments, our Provincial governments, have been investing now in further capital equipment and new facilities. We have also started to train more radiation oncologists, medical physicists, and radiation therapists.

But there is a long lag time associated with training people. Eventually one has to train people to train people. And I think that it will probably be the end of the decade before we catch up and are able to offer an adequate supply of quality service to match the increasing demand.

I do not think a similar situation obtains in the United States.

Mrs. JOHNSON. In other words, one of the unintended consequences of budget caps is that it retards the ability of a system to reorient itself toward new treatment modalities, to new illness patterns, because it makes it harder to mobilize the resources to move in a new direction at the same time you are providing services in the old direction.

Dr. MACKILLOP. I think that is true. But I think that the restraints on resource allocation that have afflicted our discipline happened in an era of great prosperity in Canada in the 1970s and the 1980s, and I think it is not correct to dignify that as if it were, in fact, a policy decision.

Mrs. JOHNSON. Well, that is very interesting.

Dr. MACKILLOP. I believe that it was a failure of forward planning, and I do not know whether that represents a lesser problem or a greater problem. But the lack of trained staff and capital equipment in the system now reflects policy decisions made 10 and 15 years ago in an era in which Canada was spending money like a drunk man.

Mrs. JOHNSON. So it was not a lack of resources; it was a lack of an ability to forward plan. But when you combine that with a lack of resources, you could get a very much more significant lag.

Dr. Walker, would you like to comment? And, also, you have some excellent charts in your testimony that you did not really go through. Would you mind quickly walking us through your charts?

Mr. WALKER. I would be happy to, Mrs. Johnson. But I do want make the point, just for correcting the record, as I was listening to Dr. MacKillop when he summarized his comments at the last point, he misspoke, I am sure, when he said that waiting times in the United States are three times longer than in Canada. He meant just the opposite.

Chairman STARK. The record will show that Dr. Walker's charts will be included in the record.

Mr. WALKER. There are some interesting charts in here. And for the most part, you can—I will leave them as read, but I think that from the point of the deliberations of this committee, the second chart in the separate page of charts called "Probability of Waiting by Income Group" is a particularly interesting one that you are free to focus on. It is beyond the presentation in the back. The charts are in order. "Total Waiting by Specialty for Canada." The next one is "Probability of Waiting by Income Group."

Do you find that chart?

Chairman STARK. Have you ever tried that in the United States, Doctor? You do not have a piece of paper big enough to show how long the people under \$10,000 in this country would wait. That bar would go all the way up to the ceiling of this room, because they never get treatment.

How do you deal with that in Canada?

Mr. WALKER. Well, no. What this is, is the probability that people of different incomes will wait.

Chairman STARK. I am telling you that the probability of somebody who is poor in this country is 100, that they will not get any care.

Now what do you in Canada do about that?

Mr. WALKER. Well, Mr. Stark, this is very interesting, and it is frequently said to me now. However, at the institute are scientists and we like to try and document things.

Chairman STARK. Aha.

Mr. WALKER. So when people say to me that there are waiting lists of this kind, I say to them that when we try to do comparable waiting list surveys in the United States, we could not get people to understand what we were talking about in terms of measuring these waiting times.

When we told them we wanted to know their waiting times for different surgeries as we measure them in Canada, they basically said that there were not any waiting times. And when people say—

Chairman STARK. I do not know—

Mr. WALKER. Excuse me.

Chairman STARK [continuing]. Whether you are smoking, but you are inhaling.

Mr. WALKER. Excuse me. Excuse me, Mr. Chairman. When people talk about waiting times, very often it is anecdotal evidence that they are referring to.

Chairman STARK. Oh, I bet it is.

Mr. WALKER. And what we have here is as close as you can get to actual measurements of this phenomenon. So I do not have any comparable—

Chairman STARK. Let me—let me—

Mr. WALKER. I do not have any comparable measurements that—

Chairman STARK. Thank you, Doctor.

Let me ask Dr. MacKillop for a moment. Doctor, do you know of—you are a medical doctor, Dr. MacKillop?

Dr. MACKILLOP. Yes, I am, sir.

Chairman STARK. How often do you hear about women in Canada giving birth to children without being able to see a physician or some kind of trained paraprofessional?

Dr. MACKILLOP. I do not, Mr. Stark.

Chairman STARK. Come to Oakland. I will give you a long list of women who are just unable to receive that treatment because they are poor.

And also can you think of many cases of people who accept, I suppose—who are getting a lot of snowy weather like we have here—but in waiting times, you schedule appointments, or your patients have to schedule appointments to see you in your practice, I presume?

Dr. MACKILLOP. Yes, sir.

Chairman STARK. And many of your patients work?

Dr. MACKILLOP. Yes.

Chairman STARK. And so as between the time they can find a day to get off from work and get to see you—I suppose we all have some waiting built into our world. I mean, do you have to make appointments? Dr. Walker would not, but do you have to make appointments to see your barber?

Dr. MACKILLOP. In Canada?

Mr. WALKER. [Laughing.]

Chairman STARK. That is all right, Doctor. We only have so many hormones, and those guys who want to waste them growing hair, let them go ahead. But I am just suggesting that—

Mr. WALKER. We follicularly challenged people who are use to such barbs.

Chairman STARK. OK. But I just guess I am saying that there are waiting times built into our normal schedules—what I think I heard earlier is that it would be a fair summary to suggest that in Canada the decisions as to waiting and/or rationing, if that is what you want to call it, are clinical decisions, for the large part made by the medical community.

Is that a fair statement?

Dr. MACKILLOP. Can I respond to that, Mr. Stark?

Chairman STARK. Yes, please.

Dr. MACKILLOP. We distinguish, as you do, between waiting while something is done and waiting for something to happen, and we acknowledge in our discussions with patients that it is often very important to wait while we complete our investigations, to wait while we have the opportunity to discuss with them the costs and benefits of treatment, before make a decision and implementing it.

But there is a real problem in the management of cancer, which is a time-dependent disease. I think this is a distinct issue from waiting for a hip replacement, where you can make the case, as the British do, that time for a sober second thought before undergoing this potentially life-threatening procedure is not a bad thing. I do not think one needs 13 months for that second thought, but you can make such a case.

That type of case cannot be made in a time-dependent disease like cancer, which is characterized by growth and by spread to other parts of the body, because in every cancer, which is localized and curable, comes a moment when it undergoes the transition to

become an incurable tumor which will inevitably kill the patient, and even when that moment comes you cannot tell. It is something that is discovered later.

Now, in Canada, we have been very challenged by this problem of waiting lists for radiation therapy, and the issues have been very real to us. Major institutions in Canada, the Princess Margaret Hospital, our premier cancer institute, which by anybody's reckoning, is one of the top six cancer treatment centers in the world, closed its door to all new referrals, except for emergencies for 6 weeks in 1989, because its waiting list had grown so long.

Chairman STARK. That is a resource problem, is it not, doctor? In other words, were the good burghers of this community willing to pony up a few dollars in taxes and you could buy additional equipment, perhaps even attract other professionals, then the people in that community would have the access to this treatment. Is that a—

Dr. MACKILLOP. I think you are again absolutely right.

Chairman STARK. You see, in my neighborhood, we have got so much extra equipment lying around, but we will not let the people in who cannot pay. So we have this interesting situation where we have got an embarrassment of the same equipment and resources you wish you had, and we have people standing out in the streets and we say I am sorry, we will not treat you if you do not have the money.

Dr. MACKILLOP. If I may respond, I do not think that our system is beyond repair, Mr. Chairman, but there are issues here. It was not through a desire on the public's part not to spend the money, nor indeed a conscious decision of the bureaucracy not to allocate the money. There was a problem of planning. We made planning errors that left the management of the system—

Chairman STARK. In the management of the system—

Dr. MACKILLOP [continuing]. Bad management, and I believe also a failure of governance. You refer to the people in your community, and I think that is one of the important issues that you are discussing today, is to give the people ownership of their new medical system, whatever that may be, and that is a problem for us in Canada. Our Cancer Foundation has a board of political appointees located in the city of Toronto. That is not a board that has been extremely responsive to the grass roots concerns of the community.

So while you are correct that if the community had been able to tell the bureaucracy that it wanted the money spent, the bureaucracy would have spent it, but we had no mechanism for this. Our community did not have the lines of communication that would have permitted it to have expressed that wish.

Chairman STARK. Let me ask one more question, if the gentle lady will let me conclude.

Mrs. JOHNSON. Yes.

Chairman STARK. The earlier witness suggested that a good bit of the cost I believe in Canada is generated by Americans coming into Canada to receive treatment. I think, if I recall, that was Ms. Priest who suggested that.

Just as a practical matter, I suspect that if I came to Canada—I guess I can drive across a number of bridges without even being

stopped—then I am, for all practical purposes, an undocumented alien, I gather. I do not know whether Canada would let me go to work or not. Frankly, I do not know what I would do there, but let us assume that I could wait tables or find suitable employment for a person of my intellect and ability. And I came to your practice or your surgery, I presume I would receive treatment. Would I have to identify myself to you in any particular way, if I were in pain, let us say?

Dr. MACKILLOP. You would receive emergency services without checking documentation. Before you got near me, I think you would probably have some check to make sure that you were an insured Canadian.

Chairman STARK. But if I were not, how would the system dispense with me?

Dr. MACKILLOP. We would bill you after the fact. You might pay, Mr. Stark, or you might not, but we would send you a bill.

Chairman STARK. You would send a bill and you have the secret police or somebody who would come down here after me and I would still get invited to the Canadian Embassy to meet with your folks?

Dr. MACKILLOP. We do not follow up on any defaulting payments.

Chairman STARK. Is that a matter of great political concern in Canada, that you are being cheated by us Americans who are sneaking in there to get medical care?

Dr. MACKILLOP. We have started to hear about it occasionally. I do not believe it is a significant political issue.

Chairman STARK. Ms. Nichols raised that issue for us in her testimony, and—are you a lawyer, Ms. Nichols?

Ms. NICHOLS. Yes.

Chairman STARK. You are suggesting, I gather, that the President's plan in dealing with undocumented aliens is shortsighted. Are you familiar with Article 8 of the Constitution?

Ms. NICHOLS. Yes, sir.

Chairman STARK. What constitutes being a prisoner?

Ms. NICHOLS. Excuse me?

Chairman STARK. What constitutes punishment or being a prisoner? Do you have to be actually in the jail to come under the protections of Article 8, which guarantee medical care only to the likes of Haldeman, Ehrlichman and Ollie North, because not giving them medical care would be cruel and inhumane punishment? If an illegal alien is detained, is that sufficient to put them under the—

Ms. NICHOLS. I am not certain.

Chairman STARK. You ought to look that up. We may have a solution, and then we could ignore the President's shortsightedness.

Ms. NICHOLS. Or if you failed to buy individual coverage under the Chafee bill, maybe you would be jailed and then covered.

Chairman STARK. I have always suggested to people who are uninsured that they just drive through Los Angeles, and when they are stopped, hit a policeman, they will need more medical care than they ever dreamed possible, but they will get it courtesy of the County of Los Angeles. It is the only small elite group in this country where there is guaranteed medical care under our Constitution.

Did you want to inquire further?

Mr. WALKER. Mr. Stark, you did raise several questions in your comments that are answered in fact from Canadian data. You raised, for example, the issue of a woman who is in a low-income group not getting access to appropriate prenatal care, and so on, and as a result may be having high infant mortality rates and that kind of thing.

It is very interesting to look at the Canadian data in this respect. A study which was done by an employee of the government of British Columbia in infant mortality amongst different income groups in Canada. We find that the infant mortality rate amongst the group experiencing the highest incidence of poverty in Canada is double the infant mortality of the income group having the least amount of poverty. This is the way they do the income quintiles in the census.

I think that kind of information ought to lead you to challenge whether or not you are in fact going to solve some of these kinds of problems. We also have identified in Canada the fact that the people who need health care do not seek it, and this has nothing to do with the fact of whether the care is available or not. In the case of these infant mortality statistics, it is not that the care is not available to low-income people in Canada. The fact is they do not seek it.

Chairman STARK. Doctor, comparing the Indian population of Canada and its location with the Indian population of the United States—and I presume by that you mean Native Americans—

Mr. WALKER. I am not comparing—

Chairman STARK [continuing]. Drawing conclusions about the impoverished rate of infant mortality—

Mr. WALKER. No, no, no.

Chairman STARK [continuing]. Is akin to putting wings on pigs and watching the sea boil.

Mr. WALKER. That is a political task, Mr. Chairman. Economists do not do that.

Chairman STARK. I thank you for your questionable contribution to the art of research. I appreciate it.

Mrs. Johnson.

Mr. WALKER. Mr. Chairman, you have completely distorted my evidence, with all respect. What this data shows is not Indian versus non-Indian. It shows infant mortality in the city of Vancouver and Victoria, two of Canada's most well-developed urban areas, with the highest quality access to Canadian health care.

The point is that you, as a concerned observer ought to wonder why it is that we have this same great disparity in infant mortality rates between low- and high-income Canadians, in spite of the fact that we have a single-payer system, with all of its supposed benefits.

The Indian population is another issue which is also included in this data, but does not in any way detract from the data for Vancouver and Victoria, which are urban, you know, quite comparable situations. It would be appropriate, for example, to compare this with say Seattle not just the Indian population.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Dr. Walker, your chart entitled "Infant Mortality Rate in Vancouver and Victoria," does describe exactly what you have just told us very vividly, that in fact the infant mortality rate amongst your poorest population is double that amongst your more affluent populations, and in fact your national health care plan has not been able to address what we consider to be one of the serious problems we face. And it is even a more serious problem for us, because our out-of-wedlock birth rate is so much higher than yours.

I would also like to mention your infant mortality chart comparing infant mortality among non-Indian and Indian populations in Canada and the United States, and I just want to ask if I am reading it correctly. The impression it gives is that the infant mortality among Indian and non-Indian populations in the United States is roughly the same, relatively close, and—

Mr. WALKER. With the Indian infant mortality rate being below the average for the overall population.

Mrs. JOHNSON. That is a good point. The infant mortality rate is actually lower among the Indian population in America than it is among the non-Indian population. Whereas, in Canada it is more than twice as much among the Indian population and the non-Indian.

Mr. WALKER. That is right.

Mrs. JOHNSON. So I think it does really raise a number of issues. I would ask you to go back to your probability of waiting by income group chart, because while the issue of waiting is not quite the same in America as it is in Canada, our ability to document it is. And it is certainly true that a poor person who goes to an emergency room gets exactly what they want immediately.

So we do not have good research on the extent to which our poor people are not getting care because they are not going, but we do have some very good demonstration projects, one in my own home town about the necessity of actually having people go out and bring people in for prenatal checks, because even though there is no transportation barrier, no day care barrier, and so on and so forth, still the prenatal checks are not something that some women are concerned about.

So I think there are a lot of different issues here, but I want to understand your chart better. If you would please go over it, I would appreciate it.

Mr. WALKER. By the way, the data upon which this is based is collected by our central statistical agency in Canada called Statistics Canada, and this is drawn from a sample of 12,000 Canadians interviewed by Statistics Canada, and the question is asked of them, have you waited for any health care treatment any time during the year, and they also collect statistics from them on the family income.

So what we have been able to do then is to take this individual survey data, it is not some sort of average, we have been able to take this sample of 12,000 people and simply rate them according to their income.

Now, the interesting thing that the chart shows is that there is very little to distinguish the waiting times experienced by people between no income and \$60,000 a year. There is some variation,

there is some up, some down, but basically the probability is about 8 percent that they would be denied or have to wait for health care.

When we look, however, at the two upper-income groups from \$60,000 to \$80,000 and \$80,000 and above—and these categories, by the way, are chosen by Statistics Canada, not by us—what we find is that there is a dramatic difference in the amount of time that these people wait. They wait, roughly speaking, half as long as the other income groups wait.

This ties in with research that we have been doing in connection with our waiting list survey and with the research that has been done at other institutions, and that is that there is in fact not equal treatment of people in the Canadian health care system.

The first reason there is not equal treatment is if you have the income like, for example, the Premier of the Province of Quebec, who recently found himself with a malignant melanoma, and you cannot get interleukin-2 in Canada, the protocol for this particular disease is not defined so that you can get interleukin-2 in Canada, he was able to go to Bethesda, Md., and get his treatment, because he can afford to do that. So that those who have income in Canada who face these waiting list problems can opt out.

We find from a study that was done at the University of British Columbia on the phenomenon of waiting times that there also is queue jumping, and that the queue jumping tends to be related to status; if you are a minister of government or if you are well connected to the medical fraternity in some way you will be able in fact to jump the queue.

What they found was that 80 percent of the queue jumping that they could identify was for nonmedical reasons. That is to say only 20 percent of people are moved up in the queue, so that they do not have to wait for medical reasons, 80 percent are moved up in the queue for some other reason. And we think that those other reasons are correlated with income, you now, the probability that you are going to be well-connected and have high income are fairly closely related.

What we are observing in this chart is the fact that high-income Canadians are in fact able to avoid, in one way or another, the problems that are experienced by the average in the population.

Mrs. JOHNSON. Thank you. That is a very interesting explanation. I appreciate your testimony.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you. I apologize once again. I had to go off to a leadership meeting dealing with health and the Republican Party.

Ms. Nichols, while I was gone, you made some comment, and I would prefer to hear it from you, about the Chafee bill vis-a-vis what happens to people who do not have insurance, since I am the principal sponsor of the bill on this side of the Capitol. Apparently you said something about people would be arrested?

Ms. NICHOLS. Mr. Thomas, I was being somewhat glib, but what I was referring to—

Mr. THOMAS. I could not tell, the way in which it was delivered. I was just talking about the content.

Ms. NICHOLS. What I was referring to was that, as I understand it, the principal claim that your bill has to being universal coverage

is an individual mandate, which means that everybody must buy coverage for themselves in order for us all to have coverage.

It has always been a question on my part, I consider that not to be universal coverage and not to be in the interest of the consumers, and I wonder how is that enforced. If you do not buy universal coverage, do you then go to jail where you can get free health coverage? I was making a joke, but there is an underlying very strong concern that I have about your proposal.

Mr. THOMAS. Well, the answer is in the bill, and if you read the bill, you will find out. We do not set up a punitive system, we set up an incentive system. What we do is we provide vouchers for the tax system beginning at 90 percent of poverty through the year 2005, to 240 percent of poverty phasing out.

We make all the changes that most other people believe are essential in bringing about a rational system, not the least of which is the malpractice reform, which we clearly see as the difference between Canada and the United States, on bringing frivolous suits with enormous amounts of money being passed around the system that have no relationship to economic damages or even non-economic damages, but have more to do with the litigiousness of society and the trial lawyers.

We make all of the antitrust changes, we make the administrative reforms, we make the insurance reforms so that small group folk can come together, and we have voluntary purchase cooperatives. After having done all of that through the year 2005, we require a premium to be paid if someone chooses not to buy insurance, not because of poverty, because we have a buy-down procedure for that, but because they simply choose not to do it, and not because it is not innovative, because we have the medisave plan, as well, if you just want to go catastrophic and take care of your preventive care.

We say when that when you go in for the services without any form of insurance, you are required to pay 120 percent of the actual costs, because society is going to get out of you the protective aspect of insurance either by paying when you get that service directly, or by getting insurance. And the first couple of times you go in and pay 120 percent of actual cost, you probably are going to shop around for low-cost insurance.

It is as universal coverage as the President's plan or as Congressman McDermott's plan, in terms of truly reaching universal coverage. So no, we do not throw anybody in jail if you do not have insurance. We simply require you to pay the societal cost of not having the insurance, and it is subject to adjustment from 120 percent to some other appropriate percentage, so that you will understand that it makes sense to buy insurance. But before we require someone to buy insurance, we make all the changes in the system that not only makes it attractive and reasonable, but easy to do that, as well. And that is in the bill.

In terms of this jumping the queue, any study on doctors vis-a-vis doctors? You indicated that only about 20 percent of the reason for jumping the queue was medically related, and the other 80 percent are nonmedically related. The fact that you are a doctor that needs some medical service, is that a medial or a nonmedical reason to jump the queue?

Mr. WALKER. Well, I think the implication is that that is a nonmedical reason, of course, but you being a physician in the system, you have better contacts than somebody else would have, for example. It is also true that people who live in urban areas that are near major centers are more likely to get treated than those people who are in rural areas where they have less good access, and so on.

While I have the microphone, may I have the opportunity to just make a mention about the people who are waiting. There is an implication, and the chairman raised it, that people who are waiting are not really needful of care. You know, it is sort of an optional kind of thing.

A recent study—which is also included in your charts here—a study completed by the Institute for Clinical Evaluative Studies, which is funded by the Ontario Government, found that of those people who are waiting for hip surgery, it is not untypical for them to wait from 7 to 13 months in severe pain for this procedure. It is not unusual for people to have had severe disability in terms of mobility and be waiting for 7 to 13 months.

So I think we do need—perhaps Dr. MacKillop's comments about waiting for intervention for cancer therapy has made the point better than I can, and that is that we have to dispel the notion that somehow this waiting does not involve any real costs to the people involved, that this is just somehow ethereal stuff that really does not matter.

These people for the most part are in pain, they are at the very least in psychological pain, often in physical pain, and this is a real cost to the people involved and it is something that really needs to be focused on, if you are considering adopting this kind of system.

Mr. THOMAS. Beyond that, doctor, I think there are a number of elective procedures which, if put off, can in fact result in someone doing more damage to themselves than would otherwise be the case. Off the top of my head, I could think of cataract surgery, which not only would provide a better quality of life for that year or more that you are waiting, but that in fact if you are somewhat elderly and still feel that you can get around—if you have a broken hip you are down, it is painful, but you are down—but if you have cataracts and you move around, you could wind up with that broken hip, by virtue of not having the timeliness benefit.

So there are a number of down-side exposures that occur any time when you are waiting, and waiting is rationing and it is always in the eye of the beholder, primarily. But when you begin to have statistical numbers show up, as you have, in terms of economic relationship, you have some concern.

Let me ask one last question. It has a bit to do with your system, again, which I am not as apprised of as I would like to be, and I am trying to. For example, in the President's offering—which is obviously not now reality, but it has to do in part with this business of choice or limiting freedom of choice—under the President's plan, you cannot go out and pick up insurance outside of the alliance structure, that basically your choice will be within that framework. As Senator Gramm said, based upon a Wall Street Journal article, that this really does limit the freedom of choice that Americans would have under the President's system.

Is there anything comparable to that in Canada, in terms of a closed buying system or choices denied by virtue of the structure that is there?

Mr. WALKER. Well, it is a very important aspect of the Canadian system that the purchase of insurance for those things which are covered under the comprehensive program is outlawed in Canada. In other words, a Canadian may not buy insurance for those procedures, and this I think turns out to be a crucial features of the Canadian system. I must say until Mr. Gramm raised it in the Wall Street Journal, I had missed it in the U.S. plan, but it is a crucial point. Because what it means is, it means that the only health care that is going to be available to anybody is the health care that is made available to everybody.

Obviously if you cannot provide insurance for procedures, then any provider of those procedures who is trying to provide more than is available under the comprehensive program is not going to be economically successful. What we have found in Canada is that there are in fact no options to the government provided plan. In other words, while ostensibly you have choice, the fact that you are unable to insure yourself, to implement that choice means that there is in fact no choice.

By the way, there is a distinction to be made here between the Canadian and the U.K. system or the English system in this regard. That is that in the U.K. system they are permitted to purchase insurance under the British United Provident Association and a number of other plans. They are able to purchase insurance for services that are covered by the national health service, and about 11 percent of the population of the United Kingdom in fact get surgeries and things done in British United Provident Association hospitals, and that option is not, as I say, available to us in Canada.

The only option we have—and this option has just recently become available—is to purchase insurance for treatment in the United States. There is a new insurance plan, operated by the Canada-American Health Insurance Corporation out of Winnipeg, which provides Canadians with the opportunity to buy insurance for coverage in the United States. Evidently, under the plan which is being proposed down here, that opportunity would be denied Americans.

Mr. THOMAS. Under the President's plan.

Another reason, Ms. Nichols, that we made the changes in our bill in terms of voluntary purchasing cooperatives. As opposed to my friend Dr. McDermott, I do believe that, under the proper structure, the insurance industry can be very creative in packaging various alternatives, and it seems to me that we do not know enough about what should or should not be done in closed systems to not allow for some kind of a private sector marketplace check on what could be offered.

If in fact purchasing cooperatives and closed purchasing cooperatives are the way of the future, I think they ought to earn it in a real world setting, rather than having them anointed by government imposing them on the structure, and I frankly believe a little competition, fair, equal competition with insurance changes that are absolutely necessary would prove the merit of the purchasing

cooperatives far more than a government imposed one, as the President does under his alliances, or even as Cooper-Grandy does under their current structure. I believe you ought to earn the changes, rather than having them awarded to you.

I yield back my time, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

I want to ask Dr. Walker and Dr. MacKillop a couple of questions. Before I do, I just want to make a couple of comments about some of the things I have heard.

I think it is important for this subcommittee and our full committee and the Congress to consider the question of why people in this country do not get medical care in some instances, and I think it is too easily answered by some in this House that the problem is only that they cannot afford it or they do not have access.

To give you an example, in my home State of Louisiana, which by most measures is not as rich as the chairman's home State of California, the burghers must find a way, contrary I suppose to the chairman's State, to provide service for people who cannot afford it.

In my State, if a woman wants to get her child immunized, she need only go to any public health center, a charity hospital, and the charge is \$5. If she says she cannot afford the \$5, the \$5 fee is waived, and yet the immunization rate for children in my home parish or county was, before a recent effort, less than 50 percent. So there is obviously some reason other than access and affordability that those folks are not getting the proper care, and we ought not ignore that.

Thanks to a recent effort to advertise that and to get people to take their children, we are now up over 50 percent. Hallelujah. More efforts like that need to be done.

Also, we have heard a lot of testimony, be it anecdotal, about why people from Canada go to the United States to get medical care. In most instances, it is because they are on a waiting list or they just cannot get that particular procedure or that particular drug or medicine in Canada, and so they come to the United States. That implies, at least to me, that the quality of health care in the United States generally is higher than that in Canada, at least with respect to some procedures and medications and treatment.

Now, we have had some testimony here today that we have this stream of Americans flowing into Canada to get health care. We have not heard any reasons why they are going, but I suspect that many of them, not most, if not all, are going because it is free, because they can get the health care free, they do not have to pay for it. I would submit that is a totally different situation and we ought not necessarily emulate Canada's system to stop that problem.

Dr. Walker, one of the issues that has been raised in the debate is the effect that changes in the health care system as proposed by the President or by Mr. McDermott, the single-payer system, will have on research and development in the field of health care. Do you have any insights, based on your experience in Canada?

Mr. WALKER. Mr. McCrery, this is a very difficult area, because we find that the data, for example, measuring amount of research

effort and so on is not very satisfactory. We do know that certainly there is not as much research activity done in Canada as there is in the United States, even on a proportionate basis, but there may be many reasons for that.

One of the things, however, that does come out in comparing the Canadian and United States systems which I think bears on this issue is the technology which is available in the two systems. I draw your attention to the chart. I have provided a technology comparison in the charts that I have given you, and it shows the availability of different kinds of technology in Canada per million people and in the United States per million people.

What you are really struck by is the fact that there is an enormous gap between the amount of technology that is available to the average Canadian and the amount that is available to the average American. Now, by inference, as an economist, I said to myself, well, if this is the way the market for technology is in the two countries, and since ultimately it is the market for technology that drives research and it is the market for new medical technologies which drives the soft research, if there is not the market for the technology, why do the research. It does not seem to me to make much sense and does not seem to stand up to reason that people will continue to invest large amounts of money in the development of new technologies which they know will not be adopted.

I think what you have to address in your own deliberations on this question is to ask yourself the question, if you adopt a Canadian style system, whether it is the kind that Mr. Clinton wants or it is the kind that Mr. McDermott wants, what is going to happen to the demand for high-tech modalities and high-tech equipment and what will be the implication of that on the research that you are doing in your country.

I think, frankly, that if the United States does adopt our system, that you will in fact find yourselves getting very much the same kind of technology that we have now eventually, and that this is going to have a devastating impact on the amount of research that is done. Because we in Canada typically do not adopt technology until it has been proven out in the United States. We look to the United States and say, well, is it cost effective, is it clinically effective. And having seen that evidence from your activities, we then adopt it, and that is why we have this lag in adoption of these new and advanced technologies.

Mr. MCCRERY. Thank you, doctor.

Just one question for Dr. MacKillop. We have heard references to the budget limitations in Canada in the health care system. Can you just tell us how those budget limitations that have been referred to affect the way that you practice medicine?

Dr. MACKILLOP. I can only tell you about the way I practice medicine and people in my discipline of cancer medicine practice medicine. I cannot make general statements.

As I mentioned, I do not think that the status of my discipline of radiation oncology in Canada relates to the current fiscal crisis in Canada, but we have a limitation on resources imposed by a more limited investment than was appropriate in radiation oncology in the 1970s and in the 1980s. As a result of that, we do not have as many facilities with as much equipment or as many

trained staff as we believe are necessary, and that I believe has had an influence on the way that radiotherapy is practiced in Canada.

I have audited the management of the commonest form of the commonest disease, nonsmall cell lung cancer, and I have audited the management of all patients in the Ontario Cancer Foundation over a period of 10 years, between 1982 and 1991. We found that across the whole system—although there was variation among the different cancer centers—across the whole system we were giving about 30 percent less radiotherapy to that group of patients in 1991 than we were in 1982 counted as the number of treatments per patient. There were big changes in some centers dropping to half of the former level of radiotherapy utilization and in some other centers the rate remained constant.

I have to tell you, Mr. McCrery, that we looked at the effect that this might have had on the outcome of the disease, and we looked at that in terms of survival as a fundamental measurement, and also in terms of probability that that patient would require further treatment to the same part of the body at a later date, as an indirect measure of quality of life, retreatment being an indicator of progression of the disease or occurrence of the disease.

And we found no difference whatsoever in the survival from this disease associated with the large decrease in resource utilization. We are talking about 15,000 patients, and the power to detect differences would have been very high. We found that the median survival over the two 5-year periods that we studied remained constant to within a week, and there was an eerie similarity in the percentage surviving 1, 2, and 3 years.

So I think that the resource constraints did alter practice, and I think that it looks as if my profession chose to cut down radiotherapy utilization in a circumstance in which we already had great doubts about the utility of intense radiotherapy utilization, and we have been able to achieve as a result quite massive savings at no expense in terms of quantity of life and no change in quality of life that we can detect in this type of audit.

I should indicate that we do not have good measures of quality of life based on a retrospective analysis of an electronic database. But if you look at the way that we practice lung cancer medicine now and compare that with the United States, we use far fewer resources and we produce the same results I believe in terms of quantity of life, and there is nothing to say that we do not produce equally good quality of life on our side of the border.

Mr. MCCRERY. I appreciate that, Dr. MacKillop, but what you are telling me is that the methodology was driven by a lack of resources that was driven by the budget, and after the fact you studied the results and found that there was no significant difference in outcome. But would you say that you got lucky on that one?

Dr. MACKILLOP. I think there was insight and intuition, but I would say you are exactly right, we were lucky on that one, but, my goodness, you are not so lucky, because in the United States you continue to practice the same over-expense over-treatment of patients in this disease that we used to 10 years ago.

Mr. MCCRERY. That is something we could possibly learn from you, and I am hopeful that we will start to study outcomes more

and develop practice guidelines and things that we can use to use our resources more efficiently. But I am not sure that I would prefer your system, which imposes methodologies on our practitioners through budgetary considerations, and we have to hope that we get lucky in each and every circumstance in the health care field.

Mr. WALKER. May I just add a footnote to this commentary? The issue of whether it is budget caps or whether it is management seems to me is just the same problem looked at from a different perspective. Dr. MacKillop was looking at it from the point of view of his one area, and very important area, of expertise, and he sees it simply as the bureaucracy not responding quickly enough to get the resources to them to keep up with the demand for cancer treatment.

But you see, viewed in a broader context, those bureaucrats and those people who are acting too slowly are operating within a politically determined allocation of overall budget, and one of the reasons why they are moving slowly is because their budget room is being taken away from them by some other competing political purpose.

I think that the lesson that Americans need to learn from the Canadian system is that when you move away from the current system that you have—where there is some politics involved in the allocation of resources, but it is basically driven by economic and market considerations—that when you move to a single-payer system, all of the resource allocation decisions will effectively become determined at a global level by politics.

What you need to ask yourselves is, is there anything about the way in which your political system currently makes decisions and allocates resources that leads you to believe that this is going to be a superior way of allocating resources, and, in particular, adapting to changing medical needs.

Because as Dr. MacKillop has pointed out, everything was fine in Ontario 10 or 15 years ago, it is the increased incidence of cancer causing a need for a change in the allocation of politically determined resources that has caused the problem. You know, you are all much more expert in political matters than I am and perhaps you could enlighten us on that issue.

Mr. MCCRERY. I appreciate your responses, and thank you all for coming today.

Thank you, Mr. Chairman.

Chairman STARK. If there are no further questions, I want to thank the panel very much, and the meeting is adjourned.

[Whereupon, at 1:45 p.m., the hearing was adjourned.]

[Submissions for the record follow.]

**STATEMENT OF JACK SHEINKMAN
AMALGAMATED CLOTHING & TEXTILE WORKERS UNION**

The Amalgamated Clothing and Textile Workers Union is acutely aware of the health care crisis in America. When we organize a non-union plant, we usually find workers and their families with no insurance, inadequate insurance or unaffordable insurance. We have members in inner cities in the North and rural areas in the South who have trouble finding a doctor despite the fact that they have a health plan. Escalating health care costs threaten the competitiveness of our companies, strain the collective bargaining system and dominate government budgets at all levels. The current regressive system of health care financing puts our firms and their domestic plants at a serious disadvantage in the global economy, threatening our members' very livelihood. Effective health care reform must come to grips with all these dimensions of the health care crisis.

Therefore, ACTWU is guided by three fundamental principles as we evaluate proposals for reform:

1. The need to provide comprehensive, quality health care for everyone. Employed and unemployed. Young and old. Rich and poor.
2. The need to eliminate waste in the health care system and effectively contain costs. The plan must reduce administrative waste and put a lid on rising medical costs.
3. The need to share the financial burden of health care equitably. That means progressive public financing, where corporations and wealthy individuals pay more than small employers and wage earners.

The American Health Security Act, HR 1200, is the only bill that fully satisfies these needs. It moves away from the employer-based insurance system toward a national social insurance system. It takes all the administrative waste from thousands of separate insurance plans and puts that money into a comprehensive benefit package that includes long-term care. It provides meaningful cost containment through an internationally proven method of bargaining with providers. It addresses issues of quality control without micromanaging health care professionals and without compromising patients' freedom to choose their doctors and hospitals. It provides funding and incentives to get more doctors into inner cities and rural areas. It assures public accountability of the health care system.

ACTWU is delighted to support this legislation for all these reasons. But we are particularly concerned about competitive issues and equitable financing in health care reform. HR 1200 fully addresses these issues as well.

Equitably Financed Universal Coverage Is Needed

ACTWU members, like millions of working Americans who now have insurance, are suffering the consequences of a health care system in which some employers get away with providing little or no insurance for their employees and dependents. This system puts socially responsible companies at an unfair and serious competitive disadvantage. And that means lost wages and lost jobs for insured workers. ACTWU firms with insurance are also paying more than companies in other countries with less expensive universal health care systems.

As low wage workers in the textile and apparel industry who are representative of low wage workers in general, ACTWU members are also concerned that universal health care be progressively financed, like their own union plan, using a percentage of payroll formula. The overall current health care financing structure is highly regressive for companies and workers. Health care reform needs to reverse that pattern so that universal coverage does not create new competitive problems for companies or severe hardship for workers.

HR 1200 would create a universal health care system with equitable financing. This would eliminate the unfair competitive advantage held by those firms who deny health insurance to their workers. Such a system would also bolster U.S. competitiveness with those countries that have affordable universal coverage.

Current System Distorts Competitiveness

Through our experience in collective bargaining and organizing, the Amalgamated Clothing and Textile Workers Union is confronted daily with the competitive distortions that result from some companies providing health insurance for their workers while others do not. Non-union firms often provide partial or no coverage or require co-payments on coverage for dependents that is prohibitively expensive. For example, before they unionized, single mothers making curtains for K-Mart at the S. Lichtenberg Company in Georgia were taking home \$150 a week. The company charged them \$68 a month if they wanted to cover their children under an insurance policy with a \$500 deductible. After paying for food and shelter, almost none of the 530 workers were able to buy family coverage. In their first union contract, the company and workers joined the national ACTWU health plan with an affordable "community" rate, no premium payments by workers and a \$200 deductible. Hundreds of children became protected by health insurance for the first time. Now the company has to find other ways to compete with curtain firms that have the non-insuring edge.

There are many ways that insuring firms are hurt by those who don't insure their workers. First, the non-insuring firms have lower operating costs and can underbid firms with insurance. Second, the insuring firms end up covering the spouses and dependents who work for non-insuring firms. This includes wives who work in retail stores and husbands or college students who work for small businesses. (About 65% of retail employees and 31% of firms with 10 or fewer workers had no company insurance in 1992.¹) Third, cost shifting by health care providers means that insuring firms actually pay the bills of employees of non-insuring firms. (About 30% of private insurance hospital bill payments cover nonreimbursed expenses of other patients.²) Finally, to the extent that the government pays the bills of the uninsured, all taxpayers, including insuring companies, pick up the tab for non-insuring firms.

HR 1200 would remove the competitive edge currently enjoyed by those firms that foist their workers' health care bills onto other companies and

¹ Employee Benefit Research Institute, EBRI Issue Brief (EBRI tabulations of 1993 Current Population Survey), January 1994.

² Economic Policy Institute, "The Impact of the Clinton Health Care Plan on Jobs, Investment, Wages, Productivity, and Exports", 1993.

taxpayers. Given the countervailing profit incentives, nothing short of a mandatory universal system can guarantee that all employers make a fair contribution to coverage and that all workers and their dependents are insured. This will take care of 85% of the currently uninsured who are the employees (and their dependents) of non-insuring firms. It also follows in the footsteps of mandatory Social Security contributions by virtually all employers.

We negotiate health plans with hundreds of small businesses. So we feel obligated to counter the hysteria that is being whipped up against mandatory employer contributions by some small business organizations. These are the same groups that said increasing the minimum wage would close businesses and kill jobs. But the actual minimum wage increases in 1990 caused no job loss.³ Now they're saying that mandatory premiums, no matter how small, will close businesses and kill jobs. They're wrong this time, too. Small business can afford insurance if it's equitably financed.

Equitable Financing is Key to Equitable Employer Mandate

While we feel very strongly that all firms should provide insurance for all their employees, we know that charging the same flat premium to every company could create new competitive problems. It could threaten the viability of some labor-intensive, low-profit-margin firms from apparel companies to retail stores. It would also continue to put U.S. firms at a competitive disadvantage internationally.

ACTWU negotiates contracts in both U.S. and Canada. We can cite many of examples of a single payer system providing the same or better coverage for less. In 1992 Levi Strauss paid premiums equal to 19% of its Florence, Kentucky plant payroll but paid an amount equal to only 4% of its Stoney Creek, Ontario (Canada) payroll for similarly comprehensive health insurance. For textile company Courtalds PLC the difference was 22% (Alabama) vs. 6% (Ontario); for two Hathaway shirt plants of the Warnaco Company the difference was 12% (Maine) vs. 4% (Ontario). A similar cost gap exists between the largest U.S. men's suit manufacturer, Hartmarx, and its Canadian competitor, Peerless, which is exporting almost 300,000 suits to the U.S. annually. Canada's pre-eminence as the largest exporter of men's wool suits to the U.S. is helped in part by Canada's less expensive national health insurance.

Charging the same high flat premium to all workers threatens the already tenuous living standards of low-wage workers. Currently, workers can't afford to buy insurance once they've paid for food and shelter. How will they feed and house their families if the premiums become mandatory and their incomes remain the same? The high price and unfair distribution of health care costs in the current system is the engine that drives firms and individuals to drop coverage. HR 1200's payroll premium would solve this problem.

³ Ibid.

Current Health Care Financing Is Regressive

The current financing of health care is extremely regressive. A recent study found that low-income families pay over twice the share of income for all health care expenses as high-income families.⁴ As a share of income, low-income families spend four times as much as high income families for premiums, even though many poor families are uninsured and don't pay any premiums. Out-of-pocket spending is even more regressive, with low-income families spending nine times what high-income families spend even though poor people can't afford to spend much at all on uncovered bills and deductibles.

The only portion of health care financing that is equitable is the portion covering programs that are paid for through personal and corporate income taxes at the Federal and state level. But other taxes, such as sales taxes, hit low-income families harder.

The Fairest Financing Method Is Also the Simplest

The majority of health care is funded through premiums and out-of-pocket spending--the two most regressive forms of financing. Fortunately, the most equitable method for financing health care, a payroll premium by firms and workers, is also the simplest to administer.

Traditional insurance premiums are flat dollar amounts that by their nature are a greater burden for low-income people. This burden is made even heavier by having different rates based on family size--the more mouths you have to feed, the higher your insurance premium. Under the current system, contingent workers--part-timers, temporaries and independent contractors--pay higher individual premiums than employees in group plans even though they often have lower incomes. Finally, smaller firms pay higher rates than larger ones.

HR 1200 provides the most equitable and simplest solution to financing health care: transforming per capita premiums into a progressive payroll premium structured like Social Security. The combination of a 8.4% payroll premium for companies (4% for small/low wage firms) plus a 2.1% payroll premium for workers would cover the costs now covered by regressive flat premiums and out-of-pocket payments.

These 8.4% and 4% payroll premiums are fair to a wide range of companies and workers. It represents significant savings for most companies that now insure their workers and a reasonable cost for those that do not. It is in line with amounts paid by our competitors in the developed nations. It automatically covers most contingent workers.

The Clinton plan creates a hybrid premium in the form of a flat rate with a payroll payment maximum of 7.9% for companies and 3.9% for individuals. These caps, along with the subsidies for small businesses and the very poor, make premium financing less regressive than the current system. But it creates a system that is much more cumbersome than a progressive payroll premium. This hybrid premium would require several billion dollars each year in

⁴ Edith Rasell, Jared Bernstein, and Kainan Tang, "The Impact of Health Care Financing on Family Budgets," Economic Policy Institute, 1993.

unnecessary administrative costs to determine employment status, family structure, employment status of dependents, and which firms and individuals are eligible for how much of a subsidy. While simplicity is supposed to be one principle of the Clinton plan, its financing is much more complex than it needs to be.

Cost Sharing Is Not Justified

The other highly regressive component of health care financing is out-of-pocket expenses, including deductibles, co-payments for premiums, uninsured portion of bills, and uncovered services (often drugs and mental health care). People with low incomes can't afford to buy the health care they need. Yet they pay almost a nine-times larger portion of their income out-of-pocket than high-income families for the health care they get. Furthermore, a single catastrophic illness can propel even middle-income families into bankruptcy due to uncovered bills.

Increasing out-of-pocket burdens have been advanced as a cost containment measure and a means to reduce unnecessary use of medical services. But, it is not clear that America overuses health care compared to our international competitors. Americans go to the doctor less and stay in hospitals a shorter period of time than consumers in every other major industrialized country. These nations get more services for less money despite universal coverage and little or no cost-sharing.

What is clear is that co-payments and deductibles discourage 24% of people with insurance from seeking the care they feel they need.⁵ What is also clear is that low-income people in America have worse health when they are subjected to cost-sharing. Americans who can't afford to go to a doctor put it off till they land in a hospital emergency room where more expensive heroic measures have a much lower chance of actually providing a cure.

Many union and non-union workers do not currently pay a portion of premium costs. Our union has seen too many families in unorganized plants "choose" not to have coverage simply because they couldn't afford it. As a result, we have insisted that our largest national tailored clothing and cotton shirt and jeans contracts have fully-employer-paid insurance.

HR 1200 uses payroll premiums to fully fund health care without any deductibles or co-payments for insurance or for medical services. This is similar to systems among our international competitors. Cost containment and the problem of inappropriate care are addressed without creating financial barriers to necessary services. We feel this bill incorporates the best way to finance health care and the most effective cost containment mechanism.

HR 1200 provides a free choice of provider and does not force workers into managed care and HMOs. Under the Clinton plan, we are concerned about how large a gap there will be between HMO, PPO and fee-for-service premiums. We fear the creation of a Medicaid-type second tier system of HMOs with low quality care and no middle-class constituency.

⁵ Mark D. Smith, Drew E. Altman, Robert Leitman, Thomas W. Moloney, and Humphrey Taylor, "Taking the Public's Pulse on Health System Reform", Health Affairs, Summer 1992, p. 130.

Any New Taxes Should Be Fair

Payroll premiums fall only on wages and salaries and do not impact non-labor income such as dividends, interest and rents. Equitable financing of health care therefore should include some payments based on total income or non-labor income. Excise taxes, such as the proposed cigarette tax, are the most regressive taxes of all. A cigarette tax would take a 72 times greater share of family income from the lowest 20% of families compared to the top 1% of families. While a cigarette tax has some justification as a health measure, it must be counter-balanced with less regressive financing provisions.

Conclusion

We heartily endorse HR 1200 not only because it would provide equitable financing for health care, but also because it would eliminate waste, control costs and use resources wisely to provide comprehensive, quality health care for everyone.

TESTIMONY OF THE AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association (AHCA), which represents over 11,000 nursing facilities, residential care centers, and assisted care facilities, applauds you for holding a series of hearings which explore the full range of health care reform proposals. We also commend Congressman McDermott for his leadership in the health care reform debate and his willingness to put forward a solution to the problems which plague our current system. However, the AHCA does not believe that the American Health Security Act (H.R. 1200) is the proper reform to our system and must oppose the legislation based on philosophical grounds.

Background

The American Health Security Act provides universal health insurance coverage for Americans effective January 1, 1995. Coverage is provided under a mechanism of global budgets. The states administer the program in conformity with federal standards for: budget; minimum benefit packages; guarantee free choice of provider; and quality assurance.

The minimum benefits package covers all inpatient and outpatient medical services without limits on duration or intensity except as delineated by outcomes research and practice guidelines based on quality standards.

States deliver health care services within a federally set global budget. The system is financed 85 percent by the Federal government and 15 percent by the states. Federal monies are apportioned among the states according to population, demography, and anticipated health status differences. For example, states with large elderly populations can be expected to require larger volume of high intensity services and will receive a higher proportion of revenues. States determine how that money is allocated among types of providers and will negotiate with providers on rates of reimbursement.

The bill covers services provided in a nursing facility, including "post-hospital" and long-term care services. The bill does not contain any limitations or caps on nursing facility services except that they must be determined to be provided in the "least restrictive and most appropriate setting."

Home care and community-based services are covered for individuals unable to perform at least two ADLs. Long-term care is financed through a \$65 monthly premium on individuals 65 years of age or older and above 120 percent of the poverty level.

The national insurance program would be financed by multiple increases in federal tax programs. They include a 7.9 percent payroll tax on employers; increasing the existing 1.45 percent Medicare payroll tax by 6.45 percent; an increase in corporate income tax from 34 percent to 38 percent for businesses with more than \$75,000 in profits; increases in the personal income tax rates from 15%-28%-31% to 15%-30%-34%, with a top rate of 38% for families with income over \$200,000 and a health premium equal to .5% of income; reforms to close loopholes in the tax code; in addition to the long-term care premium, a \$25 monthly increase for Medicare Part B and an increase in the amount of Social Security benefits excluded as taxable income from 50 percent to 85 percent.

AHCA Position

AHCA has serious concerns about the quality of long term care in a health care delivery system created by H.R. 1200. The legislation states that nursing facilities and other providers would "negotiate" with the single payer, in this case the state as the insurer, who in reality would have sole discretion of setting reimbursement rates as it chooses.

Experience with state Medicaid administration leads us to believe that reimbursement rates will fall short of the level necessary to provide quality care to our residents. In 1991, Medicaid was the primary payer for 70% of nursing facility residents, yet only provided 48% of those facilities' reimbursement. Massive cost shifting to the private sector is the reason residents can receive quality care.

Philosophically, the bill is contrary to AHCA's Quality Care for Life proposal. Quality Care for Life is based on the premise that families are fundamentally responsible for planning and providing their own future long-term care needs and that government should limit its role to providing assistance to individuals who have low income. The bill does neither. It would negate any private long-term care insurance market by establishing a single government run insurer. Furthermore, the government's role would extend to providing coverage for all Americans.

There are some positive aspects to H.R. 1200. The AHCA is pleased that coverage for long-term care services is more generous than any health care reform proposal currently before Congress. All Americans in need of services would be eligible for home, community or institutional long-term care. We are also pleased that there appears to be no cap or arbitrary qualification for institutional care.

We commend the authors of this legislation for their recognition that long-term care services must be included in any comprehensive health care reform effort. However we must maintain our position that health care reform must be a private/public endeavor allowing for limited government participation.

Mr. Chairman, thank you for the opportunity to provide this statement.

TESTIMONY OF GENE BRACEWELL SHRINERS HOSPITALS FOR CRIPPLED CHILDREN

Shriners Hospitals for Crippled Children has seventeen orthopaedic hospitals and three burns institutes in the United States. It offers medical and surgical care to children, wholly free of charge. In addition to patient care, each Shriners Hospital is affiliated with major medical centers and teaching institutions to train physicians and nurses and other allied health care professionals. Over two hundred resident physicians receive training in pediatric-orthopaedics and burn care annually at Shriners Hospitals.

All care at Shriners Hospitals for Crippled Children is financed from its endowment and by voluntary contributions from the general public and the nearly 700,000 Shriners. Over \$2.25 billion has been expended to date in the provision of health care to children. In 1993, 96% of Shriners Hospitals' operating budget was expended on patient care and research. Shriners Hospitals neither seeks nor accepts federal or state financial assistance for any of its U.S. hospitals.

The mission of Shriners Hospitals has always been to provide optimum and compassionate care for special categories of childhood illnesses free of charge. Recognition of the need for specialized hospitals for the treatment of children with polio and other crippling diseases prompted the founding of Shriners Hospitals in 1922. In the early 1960's there was only one burns institute in the United States, and it was military; so Shriners established three burns institutes for children. Presently under construction is a fourth, which will share a new facility with one of Shriners' orthopaedic hospitals.

We believe Shriners Hospitals makes the largest single contribution to the care of disabled children in the United States on a continuing basis. The annual operating budget of Shriners Hospitals (\$304 million for 1994) has exceeded the entire federal contribution to the Children with Special Health Care Needs (CHSCN) Title V state programs in each of the last five years.

Unlike other non-profit hospitals which, according to the United States General Accounting Office, provide anywhere from 2.7% to 7.9% uncompensated care, Shriners Hospitals provide 100% uncompensated care. Shriners Hospitals have always encouraged the treatment of those children whose parents or guardians are not financially able to meet the costs of treatment without substantial hardship.

To avoid any unintended adverse effects to our charitable institution and its free programs to children, Shriners Hospitals for Crippled Children suggests that the following provisions be included in any health care reform legislation adopted by the United States Congress:

1. A definition of "charitable provider" in terms such as "a provider which furnishes medical and/or surgical care wholly free of charge to its patients, and which neither seeks nor accepts direct or indirect governmental aid".
2. A provision [in addition to §501(c)(3) of the Internal Revenue Code] which specifically excludes "charitable providers" from the imposition of any provider taxes or other taxes levied to support health care reform.
3. Provisions which specifically exclude "charitable providers" from any proposed regulatory, financial or audit provisions (other than those which are directly related to patient safety) which are enacted as a part of health care reform, as well as from any provisions which would condition charitable tax exemptions on the participation of "community representatives" in institutional strategic planning.
4. Provisions to the effect that the collaboration with public hospitals, agencies or other providers in the delivery of patient care; affiliation with public institutions to provide health care education; or the pursuit of research in cooperation with public institutions or agencies shall not be considered as the receipt of direct or indirect governmental aid or support.
5. Provisions which preserve free hospital systems, like Shriners Hospitals, so they may continue to contribute to children's health care in the future.

Shriners Hospitals for Crippled Children appreciates the opportunity to submit written comments before the Sub-committee on its current and future role in the delivery of charitable health care services to the nation's children.

**ALTERNATIVE HEALTH REFORM PROPOSALS,
INCLUDING H.R. 3080, H.R. 3704, H.R. 3652,
H.R. 3222, AND H.R. 3698**

THURSDAY, FEBRUARY 10, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 1100 Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, FEBRUARY 1, 1994

PRESS RELEASE #27
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES THE FINAL HEARING OF THE SERIES OF HEARINGS
ON

HEALTH CARE REFORM:
ALTERNATIVE HEALTH REFORM PROPOSALS, INCLUDING H.R. 3080, H.R. 3704,
H.R. 3652, H.R. 3222 AND H.R. 3698

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold its final hearing in a series of hearings on health care reform on Thursday, February 10, 1994, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building. This hearing will focus on the following health care reform proposals:

- (1) H.R. 3080, the Affordable Health Care Act Now of 1993
- (2) H.R. 3704, the Health Equity and Access Reform Today Act of 1993
- (3) H.R. 3652, the Health Plan Purchasing Cooperative Act of 1993
- (4) H.R. 3222, the Managed Competition Act of 1993
- (5) H.R. 3698, the Consumer Choice Health Security Act of 1993

These bills are summarized below in the background section of the press release.

In announcing the hearing Chairman Stark said, "In addition to H.R. 3600, the Administration's Health Security Act, a number of health reform legislative proposals have been introduced throughout the 103rd Congress. On February 9, the Subcommittee on Health will hold a hearing on single-payer options, including H.R. 1200 and H.R. 2610. The hearing on February 10 will take a careful look at several other health reform proposals. The Subcommittee will examine the extent to which these proposals are designed to achieve the goals articulated by the President - namely, universal coverage and verifiable cost containment".

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

H.R. 3080 (introduced by Messrs. Michel, Archer, Crane, Thomas, Shaw, Mrs. Johnson, Messrs. Bunning, Grandy, Herger, Hancock, Santorum, Camp, Sundquist, Houghton, et al) would improve access to health insurance through small-group market reforms and by requiring all employers to offer, but not pay for, at least a standard benefit plan to employees. It would require insurance companies to make available to small employers standard, catastrophic and medisave plans and would encourage small employers to form purchasing groups. Individuals who purchase health insurance could deduct up to 100 percent of the cost. States would be given the option of allowing Medicaid beneficiaries to enroll in private insurance plans, and in such instances, the State could expand Medicaid coverage to higher-income individuals within current funding levels. H.R. 3080 would expand Community and Migrant Health Centers, and other rural health programs, and includes administrative and paperwork simplification, malpractice reforms, and antitrust reform.

H.R. 3704 (introduced by Mr. Thomas, Mrs. Johnson, et al) would require all citizens and lawful residents to obtain health insurance coverage by the year 2005, through an individual mandate enforced through the tax system. This bill includes insurance market reforms and voluntary, competing purchasing groups within health care coverage areas established by States. Employers would be required to offer, but not pay for, health insurance coverage, including a standard and/or catastrophic health plan. H.R. 3704 would provide vouchers to low-income individuals and families to purchase private health insurance, with the phase-in of the vouchers (up to 240 percent of poverty by 2005) contingent upon realization of Medicare and Medicaid savings. Individual and employer tax deductions, and individual exclusions, would be limited to the average premium of the lowest one-half of standard packages in the area. H.R. 3704 would provide funding for medically underserved areas, and includes administrative, anti-trust, fraud, and malpractice reforms, and a medical savings account option.

H.R. 3652 (introduced by Mrs. Johnson, Mr. Thomas, et al) would require States to establish voluntary purchasing cooperatives. H.R. 3652 includes health insurance reforms, including guaranteed issue and reissue, guaranteed renewal, and rating restrictions which allow for adjustments for age, gender, number of family members, and the area. Under this bill, insurers participating in voluntary cooperatives would be required to offer at least one plan combining a MediSave cash-value annuity or flexible-spending account with an integrated catastrophic benefit coverage plan, one managed-care plan, and one fee-for-service plan to a participating purchasing cooperative. Employers would offer, but not be required to pay for, their employees' plans.

H.R. 3222 (introduced by Messrs. Cooper, Andrews, Grandy, Mrs. Johnson, Messrs. Payne, Houghton, Camp, et al) includes health insurance market reforms and exclusive, mandatory, health plan purchasing cooperatives (HPPCs) for individuals and small employers with 100 or fewer employees. Under this bill, employers would be required to offer, but not pay for, health insurance coverage of employees. In addition, individuals would not be required to purchase health insurance. H.R. 3222 would repeal the Medicaid program and provide Federal subsidies for coverage of low-income families up to 100 percent of poverty enrolled in the least-cost plan through the HPPCs, with additional subsidies provided on a sliding-scale basis between 100 and 200 percent of poverty. States would assume full responsibility for long-term care. H.R. 3222 would limit employer deductions of health premium costs to 100 percent of the lowest-cost plan offering a uniform benefit package in an area. The bill would provide assistance to safety-net providers in underserved areas, and includes malpractice, reform, administrative simplification, and antitrust reforms.

H.R. 3698 (introduced by Messrs. Stearns, Hancock, et al) would require employers to withhold, but not contribute to, premiums paid to an employee's chosen insurer. Qualified insurance plans would have to provide specific benefits and cost-sharing and could not exclude coverage for pre-existing conditions, or cancel or fail to renew coverage of enrollees. The bill would require most residents of a State to purchase Federally qualified health insurance, or be covered under a State program that provides equivalent coverage. Individuals failing to purchase, at a minimum, catastrophic insurance by 1997 would be subject to a tax penalty. Employers would be required to add the value of the coverage they offered as of December 1996 to employee wages beginning January 1997. The current tax exclusion for employer-sponsored health plans would be replaced by individual tax credits for premiums and unreimbursed health expenses and for contributions to medical savings account. Federal Medicaid payments to the States would be capped, and would be calculated on a capitated basis. However, States would be given flexibility to provide acute medical care coverage to Medicaid beneficiaries. H.R. 1742 would provide new grants to States to provide coverage for low-income uninsured, and includes malpractice reforms, paperwork simplification, and antitrust provisions.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Persons submitting written statements for the printed record of the Subcommittee's series of hearings on health care reform should submit at least six (6) copies of their statements by the close of business on **Monday, February 28, 1994**, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins on February 10.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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Chairman STARK. Good morning. This morning marks the completion of a series of hearings on health care reform, and we will focus this morning on alternative proposals to the President's plan.

Yesterday, we focused on the single-payer option, and today, we will examine 5 additional bills introduced during the 103d Congress. They include: H.R. 3080, the Affordable Health Care Now Act of 1993, introduced by our distinguished minority leader, Bob Michel; H.R. 3704, the Health Equity and Access Reform Today Act of 1993, introduced by our distinguished ranking member, Mr. Thomas; H.R. 3652, the Health Plan Purchasing Cooperative Act of 1993, introduced by our distinguished member of the subcommittee, Mrs. Johnson; H.R. 3222, the Managed Competition Act of 1993, introduced by Mr. Cooper, a member of the Energy and Commerce Committee, along with Mr. Andrews and Mr. Grandy, who are distinguished members of the subcommittee; and H.R. 3698, the Consumer Choice Health Security Act of 1993, introduced on the House side by Hon. Clifford Stearns, and he was joined in that effort by Senator Don Nickles of Oklahoma.

We will examine the extent to which these proposals achieve the principal goals articulated by the President: Universal coverage, verifiable cost containment, and an equitable way to pay for them.

In the Chair's opinion, achieving universal coverage means that every resident must have a nationally guarantees, portable health insurance coverage, supported by adequate and fair financing. We will hear a variety of approaches to this problem, and the members, I am sure, will have their own comments on the various bills.

We did hear a few days ago from the Congressional Budget Office, and the bills have not had the luxury or the joy of being vetted out by that process. I am sure they will. The Chair, of course, would welcome any suggestions by their sponsors or advocates of how they think they will fair. The Chair is making book on that as a matter of fact and would be happy to let you place bets on how your particular or favorite bill will be ranked by Mr. Reischauer.

There are examples of some of these bills. We have, for instance, in Tennessee the TennCare bill which was put together by the author of the Cooper bill, and we have a chance to see how that is working in Tennessee, and I hope we will have testimony to that effect.

We will have discussions of an individual mandate, and I hope that, as we hear about individual mandates which the Chair finds intriguing, we have a way to provide the individual with the resources to fulfill that mandate.

I would just close by suggesting that those of you who, unlike the Chair, are lawyers and recognize Article 8, a simple way to provide universal coverage is to mandate that every individual have it. If they don't have it, put them in jail, and once in jail the Constitution requires they get medical care. We thereby have solved the whole problem adding the cost to the States, and we will fund it through the Senate crime bill which I am sure they are hoping we pass in the House soon.

[The prepared statement follows:]

**OPENING STATEMENT
THE HONORABLE PETE STARK
SUBCOMMITTEE ON HEALTH**

February 10, 1994

Good morning. Today, the Subcommittee on Health completes its series of hearings on health care reform, with a focus on alternative health reform proposals.

Yesterday, the Subcommittee focused on the single-payer option, H.R. 1200, introduced by our colleague, Mr. McDermott. During the hearing today, we will examine five additional health reform bills introduced during the 103rd Congress. They include:

- (1) H.R. 3080, the Affordable Health Care Act Now of 1993, introduced by Mr. Michel;
- (2) H.R. 3704, the Health Equity and Access Reform Today Act of 1993, introduced by Mr. Thomas;
- (3) H.R. 3652, the Health Plan Purchasing Cooperative Act of 1993, introduced by Mrs. Johnson;
- (4) H.R. 3222, the Managed Competition Act of 1993, introduced by Mr. Cooper, Mr. Andrews and Mr. Grandy; and
- (5) H.R. 3698, the Consumer Choice Health Security Act of 1993 introduced by Mr. Stearns.

We will examine the extent to which these proposals are designed to achieve the principal goals articulated by the President - universal coverage and verifiable cost containment.

To achieve universal coverage, every resident must have nationally guaranteed, portable health insurance coverage, supported by adequate and fair financing. None of the bills before us today comes close to the goal of universal, affordable health coverage.

One of the proposals that has received more attention than it deserves is the Cooper/Grandy bill. It does not achieve universal coverage -- leaving behind at least 25 million uninsured Americans, according to the CBO. It does not control the growth in health care spending. In fact, it would increase the Federal deficit.

The Cooper/Grandy bill is far from benign, and does more harm than good. It herds the American people into the cheapest managed care plan in town. It taxes Americans for choosing their own doctor. And, if that's not enough "reform" for one bill, it goes on to eliminate the only Federal program that currently finances nursing home care for seniors and the disabled.

One aspect of this bill that has received surprisingly little attention is the stealth Cooper/Grandy tax. It's a tax on businesses that choose to provide benefits in excess of the cheapest health plan. These employers must pay a 34 percent excise tax, unless they drop benefits, require higher contributions from workers, or eliminate health insurance coverage altogether.

The Joint Committee on Taxation and Congressional Budget Office assume employers will cut health benefits to avoid the proposed tax, and replace them with higher wages, which, of course, will be subject to payroll and income taxes.

If you want to know what the Cooper plan means for health care reform, just look to Tennessee, and see its kindred spirit, TennCare, to see how popular and successful this managed competition approach will be. It's an equal opportunity program -- hated by doctors and patients alike.

Some say that the Thomas/Chafee bill should be considered as the basis for compromise. I would agree that the individual mandate proposed by the Thomas/Chafee bill, is needed to achieve universal coverage. However, it is not sufficient to require all individuals to purchase health insurance coverage -- unless it is affordable to all who are mandated to have it.

An individual mandate, in the absence of either employer contributions or general revenues, is likely to have a minimal impact on the majority of the currently uninsured population, who cannot afford to purchase health insurance for themselves or their families. It is like trying to solve the homeless problem by mandating that each individual buy a house.

Chairman STARK. I know that you will have a much more serious and sensible suggestion from the distinguished minority leader, and I am happy, as soon as we hear from our distinguished ranking member, to recognize him.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I hope that, as we listen to these plans, we realize that what we should be doing is addressing health care problems and needs in 1994, 1995 and beyond, and not from the late 1980s.

One of the things that has occurred out there, without the Federal Government moving, are significant changes in the private sector and in States, and what we have done is taken a look at what we think needs to be done today and tomorrow, not yesterday.

We have heard some proposals that I think have fundamental flaws in them. For example, the single-payer system has the government running the health care system. Enough said in terms of that flaw. The President's plan, as we heard, increases the deficit and, more importantly in chapter 5 of the CBO report, contains new, untried, novel—but absolutely essential to the success of the President's plan—structures which, if they do not work, create a fatal flaw in the President's plan.

So, as we go forward, I think what we need to do is look at these ideas, listen to them, and unlike the gentlemen who advocate the single-payer, we are more than willing to compromise, accommodate, and work together to solve the health care needs of all Americans. I look forward to these new and novel ideas.

Thank you.

Mr. MCCRERY. Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you. I look forward to hearing testimony from all of our colleagues on the various alternatives.

I am in the process of drafting my own alternative. I am working with the legislative counsel now. I have handed out to a number of members this morning a short summary of my plan, and I hope to have an opportunity to address the subcommittee later today to take any questions that the folks have at this point.

Thank you.

Chairman STARK. We are honored to have a number of our House and Senate colleagues with us this morning, and we will begin with the distinguished Republican leader, Bob Michel, who will testify in support of H.R. 3080, the Affordable Health Care Now Act. He is accompanied by the principal sponsor from the Senate on the same bill, Hon. Senator Trent Lott.

Why don't you gentlemen lead off any way you are comfortable. Your prepared statements will appear in the record in their entirety without objection, and we would be happy to have you summarize or expand on your testimony any way you are comfortable.

STATEMENT OF HON. ROBERT H. MICHEL, REPUBLICAN LEADER, U.S. HOUSE OF REPRESENTATIVES, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. MICHEL. Thank you, Mr. Chairman and members of the subcommittee. It is a pleasure and opportunity for us to appear before

this subcommittee. You certainly have your work cut out for you, hearing not only the testimony, but then sifting it all out and, in the end, to attempt to come to some kind of consensus on one of the biggest issues, of course, that has been confronting the Congress in many years.

Since my colleague, Senator Trent Lott, and I are part of a panel that will be presenting several other Republican-initiated health care reform plans, I think it is important to outline for you the overall framework within which Republicans propose to address the health care reform issue.

The fact is, Republicans in both the House and Senate have been studying and working on the health care issue for quite some time. In the House, we established the leader's task force way back in 1991, long before the President came into office. The Senate Republican task force was established in a similar time frame.

As a matter of fact, the initial product of our task force, the action Now Health Care Reform Act, introduced in June 1992, was similar to the so-called Bentsen bill that was adopted twice by the Senate that year, and I think, if my memory serves me correctly, had the majority of members of this committee been willing to accept some of those reforms in conference, we would, in fact, have that in place today with the American people already benefitting from those reforms.

Be that as it may, our Republican proposals this year all reflect the strong view of Republicans in the House and Senate that reform of our health system is essential and should be enacted as soon as possible. They also reflect our view that there is a right way and a wrong way to reform the system and that the direction the President proposes to take us, into a massive, dictatorial, governmental-run health care system, is the wrong way to go.

Rather, our Republican proposals follow the general set of principles adopted by House and Senate Republicans last year, and these principles start with a proposition that we believe the health care delivery system needs powerful new incentives for change. Individual responsibility and control are critical. No government-controlled system can be as responsive, as high in quality, or as cost effective as a system that is based on personal consumer choice and satisfaction.

We believe that there ought to be increased access. All Americans should have access to affordable health care for themselves and their families. Americans should not fear losing their health insurance when they change jobs, move, or suffer serious illness. So we believe in portability, and, yes, improving the pathway toward eventually achieving universal coverage. We begin by talking about access before we can get to the ultimate goal of universal coverage.

We would like to maintain quality. The American medical care and technology are the best in the world. People around the globe come to America for the best care. The best research is done in our country. Men and women from all around the world come to be trained in American medical schools. Reform that jeopardizes these resources, in our opinion, is unacceptable.

We have got to provide choice. Consumers, not the Federal Government, should choose how they get their care and from whom,

and as soon as Washington starts dictating health care, Americans' freedom to choose will be jeopardized.

We want to preserve jobs. As we seek to provide all Americans with access to health care, we don't want to put Americans out of work through increased mandates and taxes on small and independent businesses.

Then, of course, we ought to have a high degree of flexibility. Health care reform should not infringe on innovative plans being adopted by a number of our States and by large and small businesses. Health care reform must be flexible enough to fit the needs of both urban and rural areas.

It ought to be fair. All Americans should be eligible for the same health care deductions. All should be able to deduct their health insurance costs no matter where they work or how they get their insurance. Today, workers in large businesses get most or all of their insurance tax-free, while the self-employed can deduct only 25 percent of their health insurance costs. Indeed, individuals buying insurance outside their job can deduct nothing.

Then I think we want to encourage individual responsibility. Reform should increase options to enable individuals to take responsibility for their health care.

It ought to be financially responsible. I will tell you, the huge Federal deficit and the recently expanded tax burden on the American people mean that any Federal efforts to assist with the financing of insurance must be gradually phased in as other government savings become available. Adding to the deficit or the tax burden is not the way to finance health care reform.

Finally, I think we must give people information about their plans and the cost of services and then let them choose. Moreover, we ought to target the factors that drive up costs such as our malpractice system and defensive medicine, the excessive paperwork and administrative burden, and the waste, fraud, and abuse in our system.

These, then, are the principles that have guided our deliberations and which unite our various ideas. Our proposals may differ in specifics, but they all adhere to the fundamental theme that the American people themselves, through their places of employment, through their communities, and within their families should be in charge of their health care.

Republicans are ready and willing to work with the Democrats now to develop and pass health reform legislation that truly fixes the problems with our health care system.

I think with what we have heard, particularly in the last week or two, that the President's health care plan, as proposed, is unlikely to be enacted.

The proposal Senator Lott and I have introduced can be the basis from which a good bipartisan health care reform is crafted. Our act is a common-sense approach to health care and focuses on fixing the shortcomings, not overthrowing the entire system simply because some of the parts are not working. It proposes workable reforms that will make things better for people now and not risky, untried concepts that will likely not be implemented until after the turn of the century.

It builds upon and encourages the many reforms already underway at the State and local level and the private sector. H.R. 3080, the House version, I might add, has 141 cosponsors, making it the bill with the most sponsors of either body in the Congress, and when you add in the Senate sponsors, we are up over 150, I believe.

So I would like to turn, then, if I might, Mr. Chairman, to my distinguished colleague from the other body, Senator Trent Lott, who has joined in support of the basic bill.

[The prepared statement follows:]

**REPUBLICAN APPROACH TO HEALTH CARE REFORM
REMARKS BY HOUSE REPUBLICAN LEADER ROBERT H. MICHEL
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
FEBRUARY 10, 1994**

I appreciate having this opportunity to appear before the subcommittee along with our former colleague, the Senator from Mississippi (Trent Lott), in support of the "Affordable Health Care Now Act."

Since we are part of a panel that will be presenting two other Republican-initiated health care reform plans, I think it important to outline for you the overall framework within which Republicans propose to address the health reform issue.

The fact is, Republicans in both the House and Senate have been studying and working on the health care issue for quite some time.

In the House, we established our Leader's Task Force on Health way back in 1991, long before President Clinton came into office. The Senate Republican Task Force was established in a similar time frame.

As a matter of fact, the initial product of our Task Force, the Action Now Health Care Reform Act, introduced in June of 1992, was quite similar to the so-called Bentsen bill that was adopted twice by the Senate that year.

Had the majority members of this committee been willing to accept those reforms in conference, we would in fact have health care reform in place today, with the American people already benefiting from those reforms.

The point is that when we have the opportunity to correct problems with workable solutions, we ought to move ahead and not delay action in order to await the development of grandiose schemes that may never prove doable or acceptable.

Our failure to act in 1992 ought to provide fair warning to us in 1994.

Our Republican proposals this year all reflect the strong view of Republicans in the House and Senate that reform of our health care system is essential and should be enacted as soon as possible.

They also reflect our view that there is a right way and a wrong way to reform the system, and that the direction the President proposes to take us, into a massive, dictatorial, government-run health care system, is absolutely the wrong way to go.

Rather, our Republican proposals follow the general set of principles adopted by House and Senate Republicans last year.

These principles start with the proposition that:

"We believe the health care delivery system needs powerful new incentives for change. Individual responsibility and control are critical. No government-controlled system can be as responsive, as high in quality, or as cost-effective as a system that is based on personal consumer choice and satisfaction.

Reform should:

1. **REDUCE COSTS.** Reform must start with putting the brakes on escalating health care costs. Such costs should be controlled by relying on knowledgeable consumers who actively participate in the health care market---not global budgets and government-imposed price controls that result in waiting lines, ration health care and inhibit technological advances.

We must give people information about their plans and the cost of services and then let them choose. Moreover, we must target the factors that drive up costs such as our malpractice system and defensive medicine; the excessive paperwork and administrative burden; and the waste, fraud and abuse in our system.

2. **INCREASE ACCESS.** All Americans should have access to affordable health care for themselves and their families. Americans should not fear losing health insurance when they change jobs, move, or suffer a serious illness.
3. **MAINTAIN QUALITY.** American medical care and technology are the best in the world. People around the globe come to America for the best care. The best research is done in America. Men and women from around the world come to be trained in American medical schools. Reform that jeopardizes these resources is unacceptable.
4. **PROVIDE CHOICE.** Consumers, not the federal government, should choose how they get their care and from whom. As soon as Washington starts dictating health care, Americans' freedom to choose will be jeopardized.
5. **PRESERVE JOBS.** As we seek to provide all Americans with access to health care, we do not want to put Americans out of work through increased mandates and taxes on small business.
6. **ENHANCE FLEXIBILITY.** Health care reform should not infringe on innovative plans being adopted by states and by large and small businesses. Health care reform must be flexible enough to fit the needs of both urban and rural areas.
7. **BE FAIR.** All Americans should be eligible for the same health care tax deductions. All should be able to deduct their health insurance costs no matter where they work or how they get their insurance. Today, workers in large businesses get most or all of their insurance tax-free, while the self-employed can deduct only 25% of their health insurance costs. Indeed, individuals buying insurance outside their job can deduct nothing.
8. **ENCOURAGE INDIVIDUAL RESPONSIBILITY.** Reforms should increase options to enable individuals to take responsibility for their health care.
9. **BE FINANCIALLY RESPONSIBLE.** The huge federal deficit and the recently expanded tax burden on the American people mean that any federal efforts to assist with the financing of insurance must be gradually phased-in as other government savings become available. Adding to the deficit or the tax burden is not the way to finance health care reform.
10. **BE WORKABLE.** Health care represents one-seventh of the U.S. economy and is too important to the American people to subject it to the major risks that would result if it were turned over to the federal government. Reforms adopted nationally must be built on what works."

These, then are the principles that have guided our deliberations and which unite our various ideas. Our proposals may differ in specifics, but they all adhere to the fundamental theme that the American people themselves, through their places of employment, through their communities, and within their families, should be in charge of their health care.

At this point, Mr. Chairman, allow me to comment on the legislative realities we all face around here.

You know and I know that the President's bill in its present form is not going anywhere.

Even if it did have a chance of passing in its present form, it would have to be on your side of the aisle.

Republicans--and what I like to think of as discerning Democrats--simply are not going to accept such a bureaucratic monstrosity.

The administration says it is going to fight all the way to see the President's bill pass in substantial form.

But you remember--as we all remember--that the administration told you last year that a BTU tax was absolutely vital and that the administration would settle for nothing less.

But when many Democrats went unwillingly along with the BTU tax in the House, it was unceremoniously dumped in the Senate--and many members of your party were left in an uncomfortable--and in some cases untenable--position.

I bring up this bit of recent history as a friendly reminder of what could and in all probability will happen to any member of the majority who is beguiled by the administration's current rhetoric about the absolute necessity of passing the President's bill.

The Administration said the same thing about the BTU tax a year ago and your members were left hung out to dry. It can happen again.

If it is the plan of the leadership in Congress to try and ram through the President's government-run health proposal without a serious effort at bipartisanship, there almost certainly will be major errors and miscalculations that will rebound negatively on those who were a part of that effort.

For bipartisanship to work, it must be undertaken at the beginning of the legislative process, not at the end when time to craft a workable proposal has run out.

Republicans are ready and willing to work with Democrats now to develop and pass health reform legislation that truly fixes the problems with our health care system.

The proposal Senator Lott and I have introduced can and ought to be the basis from which a good bipartisan health care reform bill is crafted.

The Affordable Health Care Now Act is a commonsense approach to health care reform.

It focuses on fixing the shortcomings of our health care system, not overthrowing the entire system simply because some of the parts are not working right.

It proposes workable reforms that will make things better for people now, not risky, untried concepts that will likely not be implemented until after the turn of the century.

It builds upon and encourages the many reforms already underway at the state and local level and in the private sector, not negate these reforms through the imposition of a government-run health system imposed from the top down.

H.R. 3080, the House version, has 141 cosponsors, making it the bill with the most sponsors in either body of the Congress. When you add in the Senate sponsors, we are up over 150.

Let me turn now to Senator Lott, who introduced the bill in the Senate. He will discuss the specifics of our proposal.

Chairman STARK. Without objection, we are pleased to see you back, Trent. Welcome. Proceed in any manner you are comfortable.

STATEMENT OF HON. TRENT LOTT, A U.S. SENATOR FROM THE STATE OF MISSISSIPPI

Senator LOTT. Thank you, Republican leader and Mr. Chairman and ranking Republican, Congressman Thomas, members of the Health Subcommittee of Ways and Means. It is a pleasure to be back in my old haunts. As most of you know, I was here for 16 years. I think I served with all of you but two, but I had forgotten what elegant surroundings you have over here on this side. I mean, we live in austere poverty over on the Senate side compared to this. This is the most beautiful room.

Chairman STARK. And they are building a new railroad to get there.

Senator LOTT. I don't remember it looking quite this good when I was over here. I might not have tried to move across the Capitol if it had.

I am delighted to be here, once again, riding shotgun with my good friend, the distinguished Republican leader, Bob Michel. It was a great pleasure for me to serve as his whip for 8 years, and I really learned to admire him as an individual and admire his leadership and his courage. I would like to commend him.

Particularly, I would like to commend Congressman Denny Hastert from Illinois, who was chairman, I believe, a leader of the task force that worked on this legislation. He is not able to be here today because of an illness in his family, but he did yeoman's work. I have talked to him several times, and I want to commend my colleagues in the House for the work that they have done.

We do have now 13 Senators sponsoring this legislation in the Senate. I had looked at all the different plans, and I am satisfied that this is the one that is the most commonsensical, most reasonable, most responsible, and most affordable now.

I agree with the leader. The Clinton plan as it was originally introduced is basically dead. I think that you are going to see more and more concerns being raised about the Cooper plan, and we are going to have to then move to trying to develop a consensus that a bipartisan majority can agree on that will address the real problems we have and that we can afford, and I think that is what this bill does.

I am a cosponsor of the Nickles-Stearns plan. I think they have got a lot of good ideas. I think there are a lot of other good ideas floating around here, and you see a proliferation of other bills and good ideas. I think that is good, first of all, but I think it has also been driven by the fact that clearly what is on the table from the administration is not what the American people want or need.

The big government mandates, lack of choice, costly proposal is not what is going to happen. So we must begin to try to develop a basic plan, and I think this is it, and I am delighted to be a cosponsor of this legislation.

Now, when I go back to my State, the people talk about fundamental concerns and problems. We obviously all agree we have problems in the insurance area. We must deal with portability. We must deal with access. We must deal with cherry-picking. We must

deal with the laws of insurance because you have a preexisting illness. There are certain insurance areas we all agree we ought to do something about that. So we ought to begin from that standpoint.

Most of us agree that there should be medical malpractice reform, responsible reform that would help deal with a serious problem in this area that leads to the practice of medicine, that is a defensive practice, that leads to a lot of procedures that we don't need that drive up the cost. We ought to do that.

In my State of Mississippi, it is not access to insurance. Our problem is access to any kind of medical provider. In rural areas, even if you had insurance, you can't get to a hospital, you can't get to a doctor, you can't get to a nurse practitioner. You probably can't even get to a midwife. So we must address this problem not just from the standpoint of the inner cities which we must do and try to have reforms there. We have got to make sure that the rural areas are considered in this process, and this bill does that. It has some significant proposals in the rural health care area.

So those are just a couple of the areas that I am going to be watching. I do think we need incentives, incentives for individuals to do the responsible thing, incentives for more doctors to go into the general practice, incentives to get health care providers into rural or underserved or unserved areas, and I think that there are a lot of good ideas that would accomplish that.

Are we working on House rules or Senate rules? Do I have 5 minutes or 50 minutes? Don't answer that.

This bill is paid for. I think that in these times of being concerned about unfunded mandates and just dumping the cost off on the States, you must have a financing provision in your package. This does. It phases out Medicare subsidy for seniors with incomes over \$100,000 individually or \$125,000 per couple.

It would prefund government retirement health insurance cost. It would increase the Federal retirement age from 55 to 62 which comes to just over \$17 billion, and as best as we can estimate, because the Joint Committee hasn't responded to our request to cost it out, we think it would be about \$17 billion. So our package is paid for.

Now, turning to the package, I would just like to quickly run through what this does. It does require employers without existing health benefit plans to offer to eligible employees at least one plan, meeting an actuarially defined standards of coverage. It does limit preexisting condition restrictions under all employer health benefit plans. It does require coverage of essential and medically necessary medical, surgical, hospital, and preventive services. It encourages the formulation of multiple employer health plans by removing IRS regulatory barriers involving geographic limitations and business commonality tests which now prevents such groups from using the tax-exempt trusts to lower costs.

I mentioned that it does provide a number of areas of assistance in rural health care, including rural emergency medical services with \$15 million to help get that started.

On air transport for rural victims, in Hattiesburg, Miss., we do have a helicopter service that serves probably about 7 or 8 counties. This would really be helpful in some of these rural areas just

to be able to get to a hospital in 20 minutes instead of 50 or 60 minutes. It would save a lot of lives. This legislation provides help in that area.

It does provide for increased access to community health services. In my State of Mississippi, community health services now do a great job, but we need more help in that area, and there is a provision for community coordination demonstration grants.

It does provide for Medicaid program flexibility. The States are doing a better job than we are. That is true in innovative ideas and new ideas. The Chairman mentioned the Tennessee plan. I mean, right now it is in a state of chaos, but they have launched on out there into these untried, troubled waters. They are doing something, and they can do a lot more if we would give them the flexibility in Medicaid to come up with new ideas and actually provide better help, more help to the poor that depend on this program.

It allows States to enroll in Medicaid beneficiaries and HMOs and PPOs without having to submit to all of the cumbersome waiver requirements and applications that they now have to have.

I mentioned it does have medical malpractice liability reform. There are various proposals in this area. Senator Gramm of Texas has a very strong medical malpractice liability program, but as a lawyer and one that used to be on the defense side of the equation, this one is reasonable. It is practical. It is not extreme. We can do it, and it would help with the problem, and I don't think it would run all the lawyers in the world off with its proposals.

It does have the medical savings account, medisave. I think it is a good proposal, but I think that we can work with others. We need to strengthen it, provide more encouragement there, but I would encourage this subcommittee to look at this medisave proposal. I think it is an excellent one. It has the antifraud provisions and Medicare plan changes. It has got it all.

This has been described as the minimalist plan or the incremental plan. The people that do that haven't looked at it. This is a well-thought-out plan. It is one we can do now. We ought to quit fighting over what we disagree on and find out what it is we can agree on, do it this spring, and then look to the future. Let's do what we can do, and as we go along, as we make savings, as we come up with better ideas, we can adopt those. We don't need to reinvent health care in America. It is in pretty good shape. We just need to deal with some of the problems. We need to try to improve it. At the very least, let's begin by doing no harm.

Thank you, Mr. Chairman.

[The prepared statement follows:]

HEALTH CARE REFORM-A PRACTICAL APPROACH

THE AFFORDABLE HEALTH CARE NOW ACT OF 1993

A STATEMENT BY SENATOR TRENT LOTT

FEBRUARY 10, 1994

Mr. Chairman, I come before you and this Subcommittee on Health of the House Ways & Means Committee today, to offer support for the legislation H.R. 3080, "The Affordable Health Care Now Act of 1993." This bill will improve access to health insurance, help contain health care costs, and address the areas of health care which really warrant reform. This legislation, furthermore, is widely supported with 141 cosponsors currently in the House of Representatives, and 13 cosponsors currently in the Senate. This speaks well of those who crafted the bill. It also reflects how well the American public has transmitted its message to Members of Congress, because our health system does work. However, we want it to work better.

I have spoken to countless Mississippians and others across the country about health care reform. I want to tell you this morning, there is a great deal of apprehension, or perhaps I should say fear, about what we here in Congress could possibly do to the quality of health care delivery, and the existing availability of medical treatment.

Health care reform is a subject which has now captured the national spotlight, and tapped the conscience of all Americans. It is one of the most difficult problems facing our country today. We all need and deserve health care that is **affordable and accessible**.

Rapidly increasing costs, however, have made these goals hard to reach. I looked closely at the details of a number of proposals presented in Congress, and chose to sponsor the legislative proposal of Congressman Michel in the Senate. It is S. 1533 bearing the same title, "The Affordable Health Care Now Act of 1993."

It too, is a practical approach. It will expand access to affordable group health coverage for employers, employees and their families. Also, it will help eliminate job-lock and the exclusion of such individuals from coverage due to preexisting condition restrictions.

In addressing health care reform, we must make sure that we do not sacrifice quality as we reform the present system. In addition, I believe that any plan ultimately approved by Congress, must ensure that we retain the positive things about our country's health care system, like the individual freedom to choose your own doctor and hospital.

The health care problems we face are very complex and a solution is not going to happen overnight. Obviously, we need to do something, but any reform must be carefully weighed. We need to have a full and thorough debate on all the options facing us. The issue of health care is too important simply to rush to judgement.

I urge you and this Committee to examine the merits of this legislation, this practical approach to health care reform, and favorably report it. Thank you Mr. Chairman, and I ask that my remarks be inserted in the record.

Chairman STARK. Thank you.

I must say there is very little in this bill with which I suppose anyone could disagree. That is the good news. Unfortunately, the CBO in their last scoring indicated that it would have virtually no impact on the number of uninsured in the country, and I don't think there have been any major changes in the bill since that last CBO analysis.

Now, if there have, the only question that I think I would ask you is this. Your Medicaid buy-in really is up to the States. The States could shift some money that they get to buy into Medicaid. There is the possibility that we could raise more Federal money for the uninsured, one way or another, to help the States allow a buy-in, and I want your comments on that. I mean, that would get more of the uninsured in the plan. Arguably, we would have to talk about taxes or raising some money to do it.

Let's assume we could find it. Let's assume there is a health fairy who is going to put some money under our pillow. Would you like to see the Medicaid plan expanded or an alternative which is attractive to the Chair is would you be willing to allow at no cost to the Federal Government individuals or companies to buy into Medicare if we priced it such that it paid the full actuarial cost?

Mr. MICHEL. First of all, one of the problems with our current system is I think you have got some Medicare/Medicaid recipients getting a better level of care than low-income working—

Chairman STARK. Medicare.

Mr. MICHEL. Yes. I think we accept that, and what we are attempting to do here by way of offering the States more flexibility is to allow them to assist those up to 200 percent of poverty and open up the doors to those currently without insurance. Put your thinking caps on, and if there is an opportunity out there in the insurance world to utilize that resource, give the States that option to do that.

Now, in saying so, I think we have to be candid to the insurance industry and say, "Look, folks, this gives you an opportunity, but you have an obligation, too, to try and help us see if there is a way in which we can hold costs down by spreading that risk and over a bigger pool."

I don't want to be shifting a burden, more of our mandate or a burden from the Federal level on the States. We heard from our Governors, and they have had it about up to here on that. As a matter of fact, they have their reservation about a section of the Cooper plan that puts them in a bind with respect to one of those provisions. So at least we offer it as a starting point, and then it is one of these negotiable things we would have to work out.

Senator LOTT. I might just say that I think that seniors would have some concerns about that proposal. I know that the chairman has worked a lot in that area over the years, and that is why you would like for us to really, maybe, move, but I get concerned about crossing these two.

Chairman STARK. There would have to be a firewall in the trust fund.

Senator LOTT. Yes.

Chairman STARK. It would have to be a separate section. I just used it as a structure.

Senator LOTT. Right.

In answer to your question, I do think that this proposal would provide more coverage for people without mandates. As long as we are saying that we are going to do it for you, employers are not going to do it. I think that if we encourage and move the employers toward covering more employees, working with them on it, that, in fact, they will do that.

Plus, I do think by these changes we have proposed in Medicaid that allow the nonmedical-eligible individuals to buy into the system it would help a lot of people.

Chairman STARK. Thank you very much.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I can think of worse criticisms than you are not ambitious enough. I think it is pretty obvious that the President's plan was a bit too ambitious.

It is interesting that in today's Washington Post, one Clinton adviser is quoted as saying, "We are going to have to compromise, and we might as well as do it sooner as later."

We have heard statements from other people supporting other plans that they had no interest in compromising because their plan was perfect and they didn't want it contaminated with anybody else's ideas, in essence.

My only question in terms of a general one is: If you are being criticized as not being ambitious enough, are you willing to sit down and talk about options that may be available that will allow us to move forward or are you adamant in terms of not wanting to talk about compromise at all? Where are you in terms of a willingness to look at other options?

Mr. MICHEL. We all have to start from somewhere, and I am reminded of all of the discussions we had in our Republican task force where we were very conscious of not wanting to impose another new tax. We decided if that is what some provisions were going to require, we better trim our sails to the degree that we can do the kind of things that don't call for additional taxes and the kind of unachievable increased revenue that would bring a whole plan down.

I am looking at our experience in the catastrophic health care field several years ago where I thought I was supporting a very noble venture, and it was going to be financed with \$4 a month premium income from Medicare. Of course, we had to get benevolent by adding things to the degree that we had to have a tax on a tax, and within 1 year, we were all embarrassed by having to repeal it. I don't want to repeat that.

I was here during the Medicaid/Medicare deliberations when we were talking about cost projections, and they are nowhere near today what we perceived them to be in those times. So we decided in our task force that we should be honest, forthright, and candid with the American people and say, "Folks, there is a limited amount that we can really promise you at this juncture, and we don't want to raise your expectations beyond our power and ability to deliver what we are talking about." I think, frankly, that has been part of the criticism of what the President initially proposed, raising everybody's hopes that this was going to be something for

nothing. When it comes right down to it, it has all got to be paid for in some form or manner.

Senator LOTT. If I might respond to that, I think I would describe myself as having been just about the biggest flirt in town over the past year, as I have flirted with every plan. I have looked at them.

I started off by saying I am not going to cosponsor any of them. I am going to wait for the one I can support. I wound up being a cosponsor. Well, Senator Chafee is here. I attended some of his task force meetings. I have been interested in the ideas in his plan. I am a cosponsor of the Nickles plan. I am a cosponsor of the Gramm plan. I even talked several times with Senator Breaux about the Cooper-Breaux plan, seeing if there was a way I could go on as a cosponsor, and I finally concluded that I just could not for a variety of reasons.

In the end, I finally settled on this one as being the best one, the most reasonable one, the one we can afford and one we can do now. This will be the base of the principal alternative to the Clinton plan.

Can we make some changes? Absolutely. I think we are going to make some changes in certain areas, and I am willing to work on it, but you have got to begin somewhere, and I don't want to begin up here at this reinvention of health care and then back down from it. I think we ought to begin at what do we need to do now and can we afford it, and then if we can make some adjustments on it around the edges, I am perfectly willing to work with you.

Mr. THOMAS. That is what I wanted to hear; that we are willing to sit down and try to accommodate and compromise to reach a conclusion.

Senator LOTT. If I might just say in the end, I think there is going to be a Michel-Dole-Moynihan plan.

Mr. THOMAS. Let me say the chairman said that he doesn't believe that under the CBOs analysis that we would do anything in terms of the uninsured. I think he needs to know that when the CBO analyzes this session's version, he will find that, as you correctly said, Senator, it is fully funded, and in that fully funded program is money that covers 100 percent of the deductibility for insurance for the self-employed and 100-percent deductibility for those people who are not insured and whose employer does not pay for their insurance; that if they acquire insurance, they have 100-percent deductibility, and it is paid for under your plan. That, I think, is a significant response to the question of the uninsured.

I thank the gentlemen for their testimony.

Mr. LEVIN [presiding]. Thank you.

I guess I am next, so welcome, as always.

To the minority leader, let me just ask you a few questions. You are a person of goodwill. So it isn't always easy to zero in on what may be flaws in your proposals, but let me just probe, maybe not too gently, but fairly.

In your testimony, you talk about government-imposed price controls. In your plan, as I understand it, you have a limit on the annual premium increase for small employers, a 15-percent limit. Now, how is that consistent with your inveighing against government-imposed price controls?

Mr. MICHEL. I think, again, what we want to do is pave the way for business and industry to do its share and its responsibility. I think we are trying to touch the conscience of all individuals who eventually become employers. Insurance is prevalent in large industries and a lot of our small businesses, but there are many out there that simply say they can't afford it.

Now, what we want to do, while we don't mandate that they pay for it, that you as responsible employers, encourage them to provide some kind of health insurance program. Then, again, turning to the insurance industry, "You folks in the industry have an obligation to provide in every community of this country an opportunity for pooling of resources to make that a reality."

Now, it may be utopian to think that that can come in a voluntary way, but I think we have already seen some of our business and industries moving in this direction, whether or not it has been caused by the very debate that we are holding today and have for 6 months or more now. If so, then I think we are on the right track.

Mr. LEVIN. But still you impose a limit on what insurance carriers can charge small business.

Mr. MICHEL. Yes, we do, and what we would perceive in a basic policy of some form is that the 50 commissioners of insurance could get together and make a determination among the 50 States what is a viable basic policy that ought to help us get through this. Then, of course, we would move beyond that and say then the option above that is a catastrophic plan or a medisave plan, but there ought to be an agreement beforehand among the 50 State insurance commissioners what we consider to be a basic policy, and then, hopefully, what we have prescribed there would fit that mold. Now, if it doesn't, well, we will have to make adjustments.

We are not the only ones moving in these uncharted waters and area, and the very fact that, for example, we can't even get our plan costed out specifically by CBO to give you real hard-and-fast figures, we have done the best we can in the absence of that, but as we have also heard this past week, there have been some pretty prominent people who thought the costs were going to be such and such and find that figure pretty well debunked by others who are in positions of authority.

Senator LOTT. Let me answer that. Maybe in the pure sense of your question, the answer is yes, if you are trying to get us to admit that we are not 100-percent pure as the driven so. Maybe so, but the goal there was to try to have some reasonableness, some responsible limits on excessive increases.

Mr. LEVIN. How about for larger business?

Senator LOTT. It is not a dollar amount; it is a percentage.

Mr. LEVIN. What?

Senator LOTT. It is not a dollar amount; it is a percentage. So the percentage would be applicable to large and small, but, obviously, you are talking about a higher amount would be involved for the larger ones.

Mr. LEVIN. Under your proposal, there is a 15-percent limit on premiums for small business, but none for large.

Mr. MICHEL. I think, here again, you are going to have a transition period over a period of time. I understand the administration's

plan allows those employers with 5,000 employees or more to go ahead and do your thing. Now, I look at my hometown industry of Caterpillar, for example, and it has a health care plan that ranks in the 96th percentile. It costs the company about \$6,000 per employee.

Now, I will tell you, there are not very many businesses around the country that can pay that. So you have got to accept that, that there are going to be these wide variations, but I am not altogether sure the best interests of the country are served by saying, "You way up here and you way down here, all have to come to some uniform premium." I would like to see it flexible enough that we can accommodate what we have to deal with currently and what we are thinking about down the road apiece, whether it is 5 or 10 years or whatever.

Senator LOTT. I understand, also, here that it may be because that is where the gyrations occur in that area. You don't have as much a movement up and down in the bigger business as you do in that smaller area.

Mr. LEVIN. All right. My time is up.

Let's see. Mr. McDermott is next.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I simply have one question of the two witnesses. I appreciate your quoting the Hippocratic Oath, the first line of which I used to think was "Primo non escero * * *," which is, first of all, do no harm, and I think you haven't done any harm. The question is how much good you have done in the proposal you have made.

I want to ask a question that relates to something the President has put on the table. I think we can talk about details here endlessly, but there really is a philosophical question that has to be answered, and that is this. The President has said that any bill he signs has to have universal coverage guaranteed, and I wonder how you come down on that issue. Do you think it is a right of citizenship in this country that you have health care or is it a function of something related to your employment or something else? I would like to hear your thinking on this issue.

Mr. MICHEL. My own personal feeling is I don't see anything in the Constitution that guarantees me health care coverage as we are talking about it today in specific terms. Now, there will be those who will argue that point. I just have a philosophical feeling that there are certain basic things guaranteed, life, liberty, and the pursuit of happiness. Now, you can stretch that all out and say, well, the pursuit of happiness means having the government take care of all my doggone needs. Well, I can't get myself around to accepting that.

As for universal coverage, that may be our ultimate goal, but to think that it is achievable within the immediate future, I cannot conceive that we have got the capability to do that funding-wise. In other words, what you are talking about, you are saying 15 to 20 percent of our population is the real target area, and I guess my reluctance to saying let's do it immediately is that when we went to that catastrophic health care bill, very limited in scope for the terrible things that wipe out your home, property, farm, and everything else, and when 80 percent of the people found out that, brother, they were going to have to pay a little bit more than what the

coverage was for themselves to provide for those who don't have it, they rebel, and that was nominal.

What we are talking about here in the President's plan is not nominal. These are drastic changes, and I think we better be very well alert to the magnitude of the problem before we jump over the cliff and cannot retrieve ourselves.

Senator LOTT. If I might respond briefly, I think it was unfortunate that the President chose to whip out his pen and make that kind of statement. We do that in Washington. Other presidents have done it, Republican presidents. I have done it. You have done it. We draw the line in the sand and say, "Dad gum it, if you cross that line, the whole deal is blown up."

Look, I got one, too. If employer mandates are in there, I won't vote for anything because I think it is just fundamentally the wrong way to go, but, I mean, I don't think we ought to start off by saying what we are not going to do.

That is why I like this proposal. Let's start off by saying what can we come together and agree on, and let's work from there.

In direct answer to your question, I guess, again, it is a fundamental disagreement. It is probably why we are Republicans and you are a Democrat. I do believe that every American has a right to an equal opportunity to a job, food on the table, a house, medical care, great football games, everything. Who pays for all this? What about the right of my 26-year-old son to be able to keep some of the rewards of the fruits of his labors? He works 60 hours a week.

Last year in the tax bill, we just raised the tax on the bonus he gets which is basically what he really lives on, and now 45 percent of his bonus is taken by the Federal Government, and this is not just rich people. These are people out there busting it because they are given an incentive to work hard. Doesn't he have some rights? How much is he as a young entrepreneur going to be asked to pay so that everybody can have everything guaranteed to them by the Federal Government? So I guess the answer is I agree to the right to an equal opportunity, but I just don't think the government should and can afford to just say, "We are going to give it to everybody. Come on, don't worry about it."

Mr. McDERMOTT. Let me just say I appreciate hyperbole, and I didn't think I had promised everything to everybody. We are talking specifically about health care.

I think my real concern—and Mr. Michel you brought up the people that I really worry about—those Caterpillar people. Those are people who sat out there and negotiated benefits, and if there is some kind of economic downturn, they are out on the streets of Peoria and Aurora and a lot of other places without a job and no health care, and they can be bankrupted.

I find it hard to think that if we focused on those who don't have health insurance now, the debate becomes one kind of debate, but if the debate is 80 percent or more in this country who are covered by insurance, but could lose it tomorrow and be bankrupted the next day by an illness or an injury, it seems to me that then it becomes a much different debate.

I think for you to say or for people who support you to say that they don't care, they want just the opportunity for that Caterpillar worker, "He lost his job. Well, that is too bad. I guess we don't care

what happens to him," I think that is not a political position that is sustainable in a democracy. I think that Caterpillar worker ought to have the guarantee that the President and the CBO said is an entitlement.

I mean, I disagreed with them up to the point that CBO said it is an entitlement. They changed the debate when they said that is an entitlement. I think those Caterpillar workers ought to have that. I am sure we will have a whole other debate on this.

Mr. MICHEL. The most urgent problem in our country today is not the employees of the biggest companies in this country who virtually have a guaranteed health plan and, in Caterpillar's case, a guaranteed job for 6 years by name.

These are cases of negotiated contracts which are the envy of many people on the outside.

I don't think that is the problem area for us nearly as much as these poor devils out there who really are down and out and without a job and the wherewithal to keep a family together.

Senator LOTT. If I could also say, I appreciate your hyperbole, too, Mr. McDermott, but what I am worried about, I don't have Caterpillar, but I have Engle Shipyard. My father was a pipefitter and a shipyard union member, by the way, and I worried that the Clinton plan or the single-payer plan is going to shift more costs to the business and industry area and perhaps to the individuals and people are going to lose their jobs, the low-end people.

The people out there working for my son, if his costs go up, he is going to say, "Gee, guys, I am sorry about you. I would like to help you, but this is just the final little straw that pushed you out of a job." So I do worry about the jobs that could be lost as a result of another mandate on business and industry.

Mr. MCDERMOTT. We will continue this session.

Thank you, Mr. Chairman.

Mr. LEVIN. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Mr. Leader, as you know, I was on the Republican health care task force that drafted H.R. 3080, and we completed our deliberations and marked up and finished our work, I think, in September of last year. Isn't that correct?

Mr. MICHEL. Yes.

Mr. GRANDY. You pointed out that we now have 140 cosponsors on this bill—141. How many of them are Democrats?

Mr. MICHEL. I don't see a one.

Mr. GRANDY. Are there any Senate Democrats on the bill, Senator Lott?

Senator LOTT. No.

Mr. GRANDY. I guess I would ask how do we get to where we want to go if this is exclusively a Republican strategy. I mean, I understand the criticisms that have been leveled against the Clinton plan, and there have been several in front of this committee and Energy and Commerce over the last couple of weeks, but I still do not understand how we are going to move from an admittedly, heavily regulated government-dense health care delivery system to a series of market incentives that are embraced in H.R. 3080.

The reason I explore this line of questioning is because there is apparently a new strategy that is now moving at least into some

of the Republican channels that has been advanced by, I think his name is, William Krystal—he used to be with Senator and then-Vice President Quayle—who is now advocating that we should defeat the coming Clinton-Cooper compromise.

Now, the other bill I am involved with is the Cooper bill or the Cooper-Grandy bill, depending on what State you are running for higher office in, and I was not aware of a Clinton-Cooper compromise. I don't think Congressman Cooper is, but, evidently, Mr. Krystal has this to say about our side:

There are those Republicans prepared to argue that such a result involves no compromise of conviction. That means signing on with either Cooper or Senator Chafee's bill.

David Durenberger, for example, Cooper's only Republican cosponsor in the Senate and a cosponsor of the also very similar Chafee bill says that, "Republicans already have a winning strategy, and that strategy is managed competition, which he calls a comprehensive vision consistent with Republican principles."

Senator Durenberger is wrong. Managed competition is not a Republican principle. It is massive social regulation, precisely the kind of thing the Republican Party should exist to oppose, and for Republicans to acquiesce or participate in its enactment would bring us no credit and much shame.

Did I make a terrible mistake in lining up with Democrats to try and build some kind of compromise between where the President is and where we are, Mr. Leader? I mean, is Mrs. Johnson wrong to be part of this group, and Mr. McMillan who is on the Energy and Commerce Committee and the other 26 or 28 Republicans that are trying to find some way to get from here to there? I mean, is this a sell-out? Tell me. I mean, I am in a very serious Governor's race back home. I need to know this for my political future, Leader.

I thought that finding some kind of solution here would bring credit to this party, just the way helping the President solve the NAFTA problem brought not only a dividend to the party, but to the country, but I may be wrong here. If there is going to be a strategy that moves through our conference that says trash everything right of Cooper through Chafee and then the Nation will embrace H.R. 3080, I might have to turn in my pass.

Do these comments embrace your views, Leader?

Mr. MICHEL. Let me first take this opportunity to compliment the gentleman on his contribution to our health task force. He was there every day. The same was true for the gentlelady from Connecticut, Mrs. Johnson, as well as for Mr. McCrery and Mr. Thomas. You are all on the task force and did an outstanding job. The task force met for an hour or so over a period of nearly 2 years, and the contributions the gentleman from Iowa made specifically to the deliberations of that task force were very noteworthy.

Initially, when we crafted what has turned out to be this basic bill, we wanted to get as much support as we possibly could on our side. I think there was an inhibition on the part of maybe some Democrats who might have thought we have had some good things to talk about because it was their President, a Democratic President carrying the initiative on this from the standpoint of the administration, and that they would be rather reluctant to be pictured in opposition to their President until they had more time to sift it all out.

We are in a shake-out period right now. The gentleman has a great deal of foresight, and I have no criticism of his having said,

"Look, I am not altogether sure that what we have crafted here does everything I would like to see done. I would like to go a step or two further." So I am certainly not going to condemn the gentleman for having reached out as he had to those other tenets in which he might feel comfortable, and that is how eventually around here you get people moving toward a solution.

If we were back in the old days when the Speaker would say we are going to debate this baby for 2 weeks on the floor, and we are going to have an open rule, and we are going to give you all an opportunity to amend the base bill, probably through alternatives or substitutes with the opportunity for amendment to each, and when an amendment is disposed of, you can come back with another. Through that process, you work your way up to the top of the pyramid and achieve a refined product that is basically a consensus of all the House. Oh, I wish that day would return. That would do credit for the institution probably more than anything else. Then the gentleman, who does so well on his feet, would convince members of his position in an effort to attract converts, and eventually, we would get the best product.

Senator LOTT. Let me join in that, if I could, and respond to your question.

Mr. GRANDY. Go ahead, Senator.

Senator LOTT. When I had the pleasure of serving in the House and serving as the Republican whip, we won a lot of victories in the eighties, and we always had to do it with 40 or 50 or 60 Democrats. I had a regular daily plan to work with Democrats and include Democrats in our strategy. That is how we won on important budget votes and tax relief votes. So I certainly agree with that, but you begin by getting your own troops together. You don't send out scouts and start trying to put a package together until you get your own act together, and I think that is what this bill does, H.R. 3080.

I will bet you, you can support everything that is in this H.R. 3080.

Mr. GRANDY. I wrote a lot of what is in that, Senator. Of course, I can.

Senator LOTT. So I think, at some point, we can use this as a base, and we can see if there are other things that we can reach out and do to improve it.

I don't know if you were here. Maybe you weren't, but I told you, I flirted with everything in town including the Cooper package, but I just could not bring myself to support it because there were some fundamental things in there I didn't agree with.

Now, you are talking about cosponsors. I want to also point out to you that the Cooper-Breaux package which you have signed onto, in the Senate, it only has three cosponsors, only three, one Republican and only two Democrats, other than John Breaux. So that is not exactly much of a consensus in the Senate. I mean, all we got to do is reach out and find one Democrat that will join up with us, and I bet we can do that.

Mr. GRANDY. I realize my time has expired. My question was not philosophical. It is tactical. I don't understand how we are going to get to our objective if we cut off our supply lines and begin trashing the one bipartisan effort that now exists anywhere in the Congress.

I might point out it is also bicameral. Senator Chafee, who is sitting behind you, knows that we have met regularly with his group in an effective way to try and bridge some of the differences between our bill, which I think are slight, but nonetheless of concern.

I may be wrong, but I don't understand how we are going to win the day by mustering our troops at the border and try to shoot down everything that comes flying our way, but, again, I have not been here as long as you gentlemen. So maybe there is something that I don't know about grafting a compromise, but I don't think it begins with scorched earth.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Who is next? Mrs. Johnson. I am sorry.

Mrs. JOHNSON. Thank you, Mr. Chairman. Because there are many other people to testify, I will keep my comments short. However, I did want to comment on the issue of rate constraints in our proposal because I don't think it was quite clear to my colleague from Michigan that the 15-percent constraints are really between groups, and that there are more serious constraints from year to year, and that not only does our bill do that, Senator Bentsen's bill also does that.

All of those who have thought seriously about insurance reform and the industry have accepted that it is perfectly reasonable when you are reforming insurance and eliminating the right to exclude for preexisting conditions, guaranteeing that people can buy the plan for the same prices as everyone else, guaranteeing that it will be renewed, and that you also can guarantee that there will be more modest rate fluctuations.

Certainly, we don't have to deal with this kind of issue with big employers. They are big enough to bargain good deals for themselves, and their problems with rate increases have not been the problems of the small market.

That brings me to the question that I want to pose to you gentlemen. Both of you made the point that you are proposing very specific solutions to the problems that we see. We see the problem in the small group market. We don't see a buying problem in the big group market. The kind of work that you gentlemen have done represents very common sense solutions and very practical and very forceful solutions to the real problems as we know them, but I think as we go through the details, the overall view of how these proposals will interact to control costs has been lost.

We really have two options before us. One group wants to say government will control cost. Government will set prices. We will have global budgets. We will take care of this, America. I think the big generic difference here is that we think if government changes the rules of the game and creates a different interaction of motivations and forces that cost will be controlled, and the pieces that you are proposing interact in such a way that costs will be controlled.

Now, it is true CBO has a hard time with this because, as we know, they can't deal with changes in behavior, but I would like you to talk a little bit about how your proposal does two things, specifically controls costs and specifically increases access.

Mr. MICHEL. On the access side of it, as I said, we are not mandating business and industry to pay for their plan, but you have

an obligation to offer a plan to your employees. There has got to be something.

Mrs. JOHNSON. So you are going to have to do that educational job that everyone needs done for them. Employers are going to have to do that.

Mr. MICHEL. Right, and not all of them do, obviously, today. So it has its leverage there by saying we expect you to consider this a part of doing business today as offering some health care plan to your employees.

Now, it has got to work in combination, however, with the insurance industry out there that we don't condemn out of hand. I want to keep the private sector still in the act. That is what it is all about, private versus public, but they also have an obligation, too, then to dovetail into what we are admonishing the employers to do, and they have an obligation then to help those smaller employers unable now to afford it, by putting together risk pools to stabilize the cost of insurance. I think that is the access one.

On the expenditure side, of course, we have talked here a little bit about the doctors playing defensive medicine rather than offensive medicine, and it comes by way of what has happened by the kind of malpractice cases and all the rest, and we would like to move in that area much more aggressively, so that we don't have our doctors, dentists, and those professionals so burdened with the kind of malpractice insurance premiums that they have got to pass it onto the consumer.

Medical malpractice is one, but another one is in the antitrust area. I have three hospitals in my home community and a teaching school, the Peorie Med School. Our trust/antitrust laws today are really standing in the way of a number of our hospitals moving toward doing the kind of things they say could cut their cost, but they are foreclosed because then they would be conniving with the neighborhood hospitals. We will take this portion, you take that portion, and we will take this one here and fill a void, and unless we break that down to give them the opportunity to cooperate with one another, it drives up costs, and that is one area where I think we could be very helpful.

Mr. LEVIN [presiding]. Senator, if we are going to finish, so that you can leave before the vote, why don't you answer briefly, if that is OK.

Senator LOTT. I will try to answer briefly Nancy's question because I think the Leader covered it quite well.

Just one point. Even though my brother-in-law, who is a suing lawyer, wouldn't like it, I do think that we could make significant savings with real genuine medical malpractice reform.

Also in this package is improved access to community health services. I talked particularly in my opening remarks about rural access. We have got a lot of people who just can't get to it, and I think the community health services, the migrant health centers would help, as well as some of the rural emergency and transportation provisions.

Then, finally, I do think we improve substantially access by the changes that allow employer-purchasing arrangements and changing IRS restrictions that now prohibit the ability to do what needs to be done, across State lines, for instance.

Mr. LEVIN. If it is all right, Mr. McCrery, why don't you inquire, and if you take the 5 minutes, I think we can finish up the panel, so, Mr. Leader, you can also go to vote. So Mr. McCrery will take 5 minutes, and then we will run together to vote.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you all for appearing before a subcommittee this morning and giving excellent testimony.

I did work with you, Mr. Leader, on the task force that came up with this plan, and as you know, I have not yet cosponsored the plan because I have been working on my own, and I kind of want to get it introduced first, to put my marker out there as to what I thought was the best approach before I started cosponsoring other approaches, but I can assure you, as soon as mine is introduced, I will be cosponsoring your bill and probably a couple of others.

I just want to summarize for the subcommittee the good things, the positive things that you do in your bill because I think there are many, and they ought not be overlooked.

You have antitrust reform which can be a powerful incentive to control cost in the provider community. You do have rural health care incentives which will help get access for folks out in the rural areas of our country.

You have medical malpractice reform. I do disagree with one part of your medical malpractice reform, and that is caps on attorney's fees. Philosophically, I am just opposed to telling people what they can make, regardless of whether they are doctors or lawyers, but it is a good medical malpractice reform section.

You do a lot of insurance reform which gets at some of the practical problems that people have in this country for getting coverage. For example, you do away with preexisting conditions clauses. You guarantee renewability. You limit premium increases for those people who get sick, and you increase the portability of insurance in this country.

You also provide greater access to the system by giving tax deductibility to the self-employed and not only the self-employed, but to individuals who don't have insurance provided by their employers. That is a huge incentive for folks to get into the system, get into the health insurance system.

So you have a lot of good things in this bill, and I agree with Senator Lott, this is a place where we ought to start. We ought to agree that these are things that we all can agree on and do now and get people in this country a little security in the health care system.

So I congratulate you for this effort. It is a great building block, and I am looking forward to working with you and the Senate side in crafting something this year that will give some folks some relief in this country.

Senator LOTT. Best question of the day, I thought.

Mr. MICHEL. Mr. McCrery, if I might just briefly respond.

Mr. MCCRERY. Sure, Mr. Leader.

Mr. MICHEL. Not to respond, but to take the opportunity to compliment you, too, on what you did on that task force, I just noticed the summation of what you are proposing now and will look with interest upon that, but you have always been one of those more thoughtful Members who said, "Hey, I want to check this all out.

I might have a few views of my own," and I think that is the spirit in which we have got to address this entire problem. With the time that you have devoted to the subject matter, I would surely want to give second and third thoughts to what you are proposing because they usually come from a pretty doggone sound mind, and we will be happy to take those into consideration.

Mr. McCRERY. Thank you, Mr. Leader.

Mr. MICHEL. I thank the chairman, too, for the time you have accorded both Senator Lott and myself.

Mr. LEVIN [presiding]. Thank you. It has been our privilege, Senator. Glad you were here. Welcome back.

Senator LOTT. Glad to be back.

Mr. LEVIN. Now, you can go back to the luxurious quarters on the other side. Say hello to a friend of mine over there.

Senator LOTT. I will.

Mr. LEVIN. Senator Chafee, why don't you take the witness chair. I think Mr. Stark will be here in 1 second. We know that you have some rigorous time limits. The minute he gets here, we will start. Let me go and vote, but he should be here any second.

Look who is here. What timing.

Chairman STARK. John, we will just start, and as the others on the panel return—and if you have to leave before we have completed inquiry, that is fine.

I will now recognize our good friend, the Senator from Rhode Island, John Chafee, with whom this subcommittee has worked, at least on the 9 years I have chaired it, on the other side of the Capitol on a variety of Medicare and health issues. We have worked closely and have a great relationship.

I welcome you. You will be joined at the completion of this vote by our ranking member, Bill Thomas; Hon. Nancy Johnson from Connecticut; another member of the subcommittee, Hon. Fred Grandy; Mr. L.F. Payne, another member of the full Ways and Means Committee; Congressman Cliff Stearns; and Senator Nickles, if he is able, because of a previous engagement, to join in the group.

Senator, why don't you proceed. Your prepared statement will appear in the record in its entirety, and if you would like to enlighten us or expand on your testimony, why don't you proceed in any manner that you are comfortable.

I recognize that our first panel went longer than was anticipated, and we appreciate your patience. I understand that you have a pressing engagement that you have put on hold, and if you have to leave before the full panel has completed their testimony, we will certainly understand.

STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator CHAFEE. Thank you very much, Mr. Chairman. Before I start, I want to say how much I have enjoyed my relationship with you over these many years as we have worked on Medicare. Those sessions have gone late into the morning, the early hours of the morning. I think we have been at it 2:30, 3, and 4 o'clock in the morning, and it has always been a treat to work with you. I don't

think anybody has better credentials than you do in the field of health care.

Chairman STARK. I hope my wife is listening. I am never sure she has really believed that.

Senator CHAFEE. Well, I can guarantee to her where you were in many of those late nights. We were together in the Capitol and various committee rooms around here.

Mr. Chairman, I won't go through the similarities that exist in the plan that we have, the ones that you are familiar with, insurance market reform, antitrust reform, reforming medical liability, increasing funds for essential community providers, like the community health centers, cutting administrative cost, making health insurance deductible.

What I would like to touch on are some of the fundamental differences that exist between our plan and the Clinton plan. First, let me say I want to credit the administration, President Clinton and Mrs. Clinton, for bringing all of this up to the front burner. But for what they have done, we wouldn't be where we are now in discussing health care. So both the President and Mrs. Clinton deserve a lot of credit.

While there are many, many features that are similar, I'll touch on those and first touch on some of the major differences.

Our proposal does allow for the establishment of private group purchasing organizations, but we don't establish a single mandatory health alliance controlled by the Federal Government and the States as called for in the administration's proposal.

For example, in my State, we don't have any businesses with more than 5,000 employees except possibly Brown University and the Rhode Island Hospital. Outside of that, nobody works for a company that big. So every man, woman, and child in our State would be required to purchase health insurance through an alliance. We have great concerns about them, and we really don't think that they can simultaneously enforce all of these new regulations and at the same time be responsive to the needs of the consumer.

Chairman STARK. If the Senator would yield, my guess is that there aren't the votes in the House to create them. I have yet to find anybody who wants them, and I would certainly join with you in that. There have got to be simpler ways to do this, and there has got to be a more flexible way. So I think you are quite right on that point.

Senator CHAFEE. All right. So I am on a roll here, Mr. Chairman.

My second point is that our proposal does not contain the backup insurance premium caps. We believe that the substantial insurance reforms we provided for and changed incentives will stem the growth of health care cost.

As you and I know, we have worked on this together so many times. The Federal Government hasn't had a great deal of success in trying to regulate prices. As you know from the reconciliation conferences we have been on, the troubles that come with trying to micro manage payments to health care providers, for every price we set, we face a host of requests for exceptions. There are exceptions to the DRGs. There are exceptions to the RBRVS, physician reimbursement scales that we have worked on. So I don't have

much faith that we can set premiums in such a way to ensure that the goal of health care reform can be achieved.

The third thing is we do not create, and to use the lingo of the trade, we don't have an employer mandate. We have an individual mandate, and we don't have the complicated system of discounts or subsidies envisioned in the administration's proposal. My written statement goes into a little detail on that.

Last, we do have compelling differences between our proposal regarding new Federal obligations. As you know, there are new entitlements in this program, whether it is a entitlement for early retirees or an entitlement for everybody getting covered very, very quickly.

I want to state very clearly that our bill provides for universal coverage. I agree with the President on that. I think it is an absolute necessity. You are not going to get control of the cost of health care in the United States in my judgment without universal coverage.

[The prepared statement follows:]

**Testimony by Senator John H. Chafee
Before the House Ways and Means Subcommittee on Health
February 10, 1994**

Mr. Chairman and Members of the Committee, thank you for giving me the opportunity to discuss the Health Equity and Access Reform Today (HEART) Act. I believe that most of us in Congress share the President's same basic goals with respect to health care reform. We want to slow the rate of growth in health care costs, and ensure that all Americans have high quality and affordable health care coverage.

There are many similarities between the legislation that Representative Thomas and I have introduced, the many other proposals under consideration, and the President's proposal. These similarities include such things as reforming the private insurance system; changing antitrust laws; reforming medical liability; increasing funding to essential community providers -- such as Community Health Centers; providing subsidies to low-income individuals; cutting administrative costs; making certain that health insurance is deductible, and focusing on primary and preventive care.

These similarities serve as an important starting point for health care reform. I do not believe, however, that they alone will solve our health care problems. Without universal health insurance coverage, the ability to control rising health care costs will continue to elude individuals, providers, businesses and government -- especially the federal government.

There are some fundamental differences between our legislation and the proposal put forward by President Clinton.

First, although our proposal does allow for the establishment of private group purchasing organizations, we do not establish a single mandatory health alliance controlled by the federal government and the states, as called for in the Administration's proposal. Under that bill, for example, in my home state of Rhode Island, where there is no business

with greater than 5,000 employees, every man, woman and child would be required to purchase health insurance through an Alliance.

We have great concerns about the ability of such a powerful entity both to enforce new regulation and simultaneously respond to the needs of consumers. Thus, in our proposal, system reforms are accomplished without the mandatory alliance structure.

Second, our proposal does not contain "back up" insurance premium caps such as are established under the Administration's proposal. We believe that substantial insurance reforms and changed incentives for providers and consumers will stem the rate of growth in health care costs.

We have not had much success in regulating prices in this country. Those of you who have served, as I have, on budget reconciliation conference committees, have witnessed firsthand the headaches associated with micromanaging payments to health care providers. For every price we set or regulation we impose, we face a host of requests for exceptions.

When we established Medicare DRG's the intent was to move toward a national rate for each procedure. Yet, each year we have moved farther away from that goal by varying the updates based on types and locations of hospitals.

Even the concept of the Resource Based Relative Value Scale, for Medicare physician reimbursement, did not survive in its original structure, and thus is still based in part on historical charges rather than the value of the service and actual practice costs.

Based upon my experience, I have little faith that we can set premiums in such a way as to ensure that the goal of health reform can be achieved.

Third, we do not create an employer obligation to pay 80% of the high insurance premium -- a provision that looks remarkably similar to a new payroll tax. Nor do we create the complicated system of discounts or

subsidies envisioned in the Administration proposal. While at first glance such a requirement seems politically popular, upon closer examination it looks much less enticing.

Most economists agree that such an employer contribution is passed on to employees through lower wages and fewer jobs, and perhaps in higher prices for consumer goods. Indeed, organized labor is quick to say that it has for many years negotiated health benefit expansions in lieu of wage increases. If one agreed with that argument, why go through the process of creating such a massive system of alliances and employment based subsidies, when a simple and direct system of individual and family subsidies can be created that will target federal assistance to those most in need?

Last, and perhaps the most compelling difference between our proposals is our approach to new federal obligations. The Administration has chosen to propose massive new federal spending and to promise new entitlements to a wide group of individuals -- not only the uninsured -- with no guarantee that the savings will accrue to pay for them.

Our proposal, on the other hand, contains an annual assessment of our progress and an automatic mechanism for adjustments. If we are right about reform, spending and savings will go into effect smoothly, but if we are wrong, our proposal forces us to make immediate adjustments or the phase-in of vouchers will automatically be scaled back.

We have heard CBO's testimony. We believe that our approach is the only one that can lead to a truly reformed system -- one in which currently distorted relationships are repaired and the potential for the creation of new distortions is minimal.

What the CBO has made very clear is that any estimate of comprehensive reform is only as good as the assumptions made by those doing the estimating. Today, those assumptions can only be based on historical patterns -- the very patterns we intend to turn upside down!

Thus, the only way to ensure that we do not bankrupt our children, is to impose a system of annual review with serious ramifications if action is needed, but not taken.

In closing, let me emphasize that I believe it is possible for Congress to enact comprehensive health care reform this year. In the history of the health care reform debate, the various factions have never been closer. With good faith and hard work we can achieve what so many before us have tried and failed to bring about-- enactment and implementation of responsible health reform.

I look forward to working with my colleagues in the House and Senate, as well as with the Administration, to enact a health care reform bill that will achieve the goals of slowing the rate of growth in health care costs, and ensuring universal health insurance coverage. Thank you, Mr. Chairman.

Chairman STARK. I will take a little advantage here until the rest return. Let me state my concern with your universal coverage, Senator. Dependent on the savings, early on in your statement, you said we haven't had much luck in getting the savings. So I am unwilling to leave that to chance. That may be my fault that I haven't been able to get the savings, and maybe it is important in some of the savings plans that you have had, but I am unwilling to tell the American people that they will have coverage which is what I want to do, the President's bottom line, unless I can go down the line and over 5 years find the money to pay for it.

Let me ask you just a question, quickly, on one of the things in which we do agree, and that is in the area of insurance reform, while the rest of your panel is getting their seats.

On the community rating, could you just briefly for me outline what you would do. Would you let them rate by age band? Would you let them rate by community? Would you phase in or how quickly would you move? Could you just give me a quick summary of how you see that.

Senator CHAFEE. We do allow for an age band. Outside of that is total community rating.

Chairman STARK. Yes.

Senator CHAFEE. So that is there, and why do we have it? We believe that it is important to have that difference between the younger group and the older group.

Chairman STARK. Let me leave you with one problem, and you could perhaps respond to me later. I, like you, want to see open enrollment, no medical underwriting, and community rating. Here is the problem I see with the age rating. There will be some folks who could; say, an employer with a group of 20-year-olds. They could run for 10 years in a self-insured plan under your bill or buy it from the insurance company and then suddenly abandon their plan.

In a full community rating without age, the younger people would pay more than the average and older people less, but the younger people would in effect be paying into a reserve fund that would keep their premium lower. Let's say 40 is the median age for a rating. So, from 40 to 65, they would pay a little less, from 20 to 40, they would pay a little more, and I am afraid that a big plan might quit when its average employers got older.

Say, a computer company that starts with 20-year-olds, they go for 10 or 15 years. They quit and dump their responsibility either onto another insurer or if there is a Federal backup plan, and I am not quite sure how we could push these self-insured people to compensate or they might get an advantage, and you can stew on that a little. The insurance companies aren't quite sure, and if you get an idea how we could deal with that, it could make this age banding more fair. I will leave you with that.

Mr. McDERMOTT. Would the gentleman yield just to have a clarification while I think about your proposal?

What is the age at which you think there should be a break? Is it at 40 or 45 or where does the age band start?

Senator CHAFEE. The NAIC, we have asked them to recommend an age band.

Mr. McDERMOTT. Thank you.

Chairman STARK. Now that the rest of the panel is here, I apologize. We were just trying to accommodate Senator Chafee.

Senator CHAFEE. By the way, the variance would be 20 percent to start with, maximum variance, and then come down to 10 percent at the end of 5 years.

Mr. Chairman, you were kind enough to note that I had this firm commitment, and I apologize.

Chairman STARK. Please, John.

Senator CHAFEE. I am glad that Mr. Thomas is here, and we have got some good backup folks who can help out.

Chairman STARK. Bill doesn't know all of the tough questions you have laid out before us that he is going to have to answer. So we will let you sneak away.

Senator CHAFEE. Well, I wish you would rephrase it in a different way than that, Mr. Chairman.

Chairman STARK. Thanks very much for your patience. We appreciate it, Senator.

We are just going to take our colleagues in order.

Mr. McDERMOTT. Mr. Chairman? Senator Chafee, I have been on panels with him. He doesn't sneak away. He will stand and fight.

Chairman STARK. We are now proud to recognize our ranking member, Hon. Bill Thomas who we can follow on with Senator Chafee's testimony on the Thomas-Chafee bill.

STATEMENT OF HON. BILL THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. THOMAS. Thank you, Mr. Chairman. That is H.R. 3704 over here, and I do want to note that now is a good time to begin looking at specifics and alternatives because I keep reading literature which indicates that the Chafee-Thomas bill or the Thomas-Chafee bill and the Cooper-Grandy bill are so much alike.

I think you will find that in secondary areas, there are a lot of bills that are alike in terms of areas that people think should be dealt with at the Federal level in terms of malpractice, antitrust, administrative reform, small group insurance reform, and a number of other areas in which I think most bills address those concerns, unless they want to take it all the way from the private sector and give it to the government.

For someone to say there are not significant differences between my approach and that of the gentleman from Tennessee and Iowa is to, one, either indicate your ignorance that you haven't read the bills, or, two, for political purposes, they are very anxious to lump them together.

There are two fundamental principles in the Chafee-Thomas legislation which I think should not be ignored and, frankly, cannot be ignored now after the CBO testimony. One is that I concluded that this debate has reached a point in the American society that there has to be universal coverage. I believe we provide universal coverage. We provide it in a way that the President today thinks probably is far more attractive than he did a week ago, prior to the CBO announcement, for obvious reasons and for the reason being it is reasonably funded in a way in which it will not have a negative deficit impact.

In addition to that, we do not impose by government edict a new, novel, academically approved restructuring of the health care delivery system. We, of course, provide for purchasing cooperatives, believe that they are new and novel ideas, notice that they are attractive to a number of regents, but do not believe that by government edict they ought to be awarded the status of winner.

We, as we have done in California, allow for purchasing cooperatives, but, with the other changes that have been made, create a far more competitive marketplace and say that if, in fact, they are destined to be the primary structure, they should achieve it through the marketplace and not through government edict.

The other thing, I think, that we have to do after the CBO pronouncement is to begin to understand that we have got to look at solutions to problems for the mid-1990s, not to the late 1980s.

The Department of Labor has just recently released statistics that show in 1990 the medical price inflation rate was 9.6 percent. In 1991, it went to 7.9 percent. In 1992, it went to 6.6 percent. Just this last fiscal year 1993, it was at 5.4 percent. You cannot deny that trend. In fact, in December 1993, it was at 4.4 percent.

I think what you are finding is that, based upon the changes made in the States and changes made in the private sector to the increased cost for health insurance, under the rules that we have allowed, you have seen some long-term structure changes.

Dr. Stu Altman and I had a discussion in front of this committee about whether or not these changes were, in fact, structural. He tended to agree with me that he believed that these changes were structural and that we need to make additional changes to improve the structural changes that are attempting to take place out in the private sector and at the State level.

One of the things I think we should not do is to say that we need to fundamentally change the structure when all that has occurred out there over the last decade is that people have been playing under the rules that we have laid down. I think it is fundamentally unfair to complain that insurers, third-party payers, and those who get to write off any and all cost of insurance should now give up the opportunity to be creative under a new set of rules and let the government run the program.

I had hoped and tried and lost by two votes on this panel in 1983 to cap fringe benefits. Had we done so at that time, I believe a discipline would have taken place which would not have created the enormous increases in costs in the late 1980s. We still need to do that, in my opinion. We have got to talk about making changes in the insurance industry, so that the new rules will allow all to participate.

Finally, let me say that when you come to financing, the Chafee-Thomas proposal, I think, is probably the most prudent one around. I think you will find that CBO will, in examining our bill when they finally give us the report, clearly indicate that, as opposed to the President's bill, we will not have a negative impact on the deficit. It is written in such a way that cannot have a negative impact on the deficit.

If you will examine the tax cap as we have incorporated it in this legislation, based upon the last Congress' bill that I introduced to the Joint Tax Committee's analysis, the kind of tax cap that we

propose will not only bring about some cost control and discipline, but it will provide sufficient revenue to provide 100-percent deductibility under the cap for the self-employed, something we have tried to do repeatedly, but haven't been able to find the money for. In addition, it will cover the costs of all people who now pay for their insurance when the employer does not contribute up to the tax cap.

Beyond that, the Joint Tax Analysis indicated that there was about more than \$7 billion available to begin the process of issuing vouchers to those individuals, beginning at 90 percent of the poverty level and working up through the year 2005 to 240 percent of the poverty level, partially funded by the reduction in Medicare from a 12 percent a year increase to a 7 percent a year increase over that 10-year period. This would create, in fact, universal coverage through the individual mandate, fully financed, without a negative impact on the deficit.

I think those proposals clearly structure a bill significantly different than Cooper-Grandy in its scope, in its content, and in its financing, and that, Mr. Chairman, I think is a significant difference, and I thank the gentleman.

[The prepared statement follows:]

Statement of the Honorable
BILL THOMAS
Member of Congress, 21st District of California

before the
Committee on Ways and Means
Subcommittee on Health

February 10, 1994

Mr. Chairman, thank you for this opportunity to address the Subcommittee today along with my good friend Senator Chafee. The President has challenged this Congress to pass a health care reform bill that will provide universal coverage to every American and slow the growth in health care costs. I am pleased to present to the Subcommittee the bill introduced by myself in the House, H.R. 3704, and introduced by Senator Chafee in the Senate, S. 1770, which would accomplish both of these goals over a reasonable period of time and in a rational manner.

The Chafee/Thomas bill requires that, beginning in the year 2005, every citizen of the United States must be covered, at least at the minimum benefit level, by a health insurance plan. In order to assist low-income individuals and families to meet this requirement, the bill provides vouchers to those with an income up to 240% of the poverty line, on a sliding scale based on ability to pay, with those at the poverty level receiving a 100% subsidy for the basic benefit package.

In addition to the individual mandate and the federal buy down for low-income individuals and families, the Chafee/Thomas bill includes several other crucially needed, and widely accepted, reforms to the health care system to ensure that every person in the United States has access to quality health care. The Chafee/Thomas bill would:

1. Prohibit insurance companies from excluding people with a preexisting condition from coverage and guarantee renewability of coverage.
2. Require all employers to provide information to their employees on basic benefit packages that are available in their health care area and deduct any premiums from their checks.
3. Encourage the development of voluntary purchasing cooperatives, of which there can be more than one, in the health care areas developed by the States.
4. Extend 100% deductibility of health insurance costs to both the self-employed and the individual who must pay all or part their own insurance premiums.

6. Give States flexibility to reform their Medicaid programs, allowing them to cover more people with the same or fewer dollars.
7. Develop and expand programs to increase the number of primary care physicians and improve access to quality health care services in underserved rural and urban areas.

The Chafee/Thomas bill will result in universal coverage, but the approach differs from the President's in two major aspects.

First, the Chafee/Thomas bill would not create a new federal bureaucracy to enforce another mandate on American business. Not only is an employer mandate an onerous requirement on low-wage companies, it is an inefficient way to provide assistance to those who currently do not have insurance.

As proposed by the President, the employer mandate would require a new structure be established in the Department of Labor to enforce the requirement on business. In addition, as this Subcommittee has heard from several economists, it is not the employer but the employee who ends up paying for the mandate through lower wages. This was echoed by the Congressional Budget Office in their report on the President's plan. Proponents of the Chafee/Thomas believe that it is more efficient, more cost-effective and more honest to require the employee to have insurance and then provide assistance directly to those who need it, instead of funneling that assistance through a smoke screen of employer regulations and subsidies to businesses.

Second, the Chafee/Thomas bill would attain universal coverage in a manner which ensures that the program will not add to the federal budget deficit. When the First Lady testified before the Ways and Means Committee last year, I asked her whether she would accept a provision which would require that the budget cuts in the President's plan be realized before additional benefits are provided. Her answer, in essence, was "NO." As we heard on Tuesday during the testimony of Dr. Reischauer on the Congressional Budget Office report on cost estimates of the President's plan, during the six-year period beginning fiscal year 1995, the plan will increase the deficit by \$70 billion, and that is assuming that Congress will have the political fortitude to enforce the strict premium caps and implement the Draconian

cuts in Medicare and Medicaid. Health care reform must be fiscally responsible or it has the potential of bankrupting future generations.

The Chafee/Thomas proposal, on the other hand, is fiscally responsible. It would require that specified reductions in Medicare and Medicaid spending -- the reductions are far less than those proposed in the President's plan -- are realized before the vouchers are phased-in. It also includes a cap on the deductibility of health insurance costs, which is set at a level which still provides consumer choice, to cover the cost of providing a 100% deduction to self-employed workers and individuals who must pay all or part of their health care premiums.

Aside from reducing federal tax expenditures, the tax cap also creates discipline within the health care system to reduce costs. Currently, with an unlimited amount of health insurance costs that can be deducted by the business and excluded from income by the employee, there is no incentive to prioritize health care needs and negotiate the best rate possible. A tax cap would force employees and employers to think more about what they want in their health care package and what they are willing to pay.

The Chafee/Thomas bill also includes several other provisions designed to reduce the growth of health care spending in the United States. Although the current downward trend in medical-care price increases is a positive sign and demonstrates that the strict cost control measures included in the President's plan are unnecessary, it does not mean that further cuts in wasteful spending are unnecessary.

First, the Chafee/Thomas bill would eliminate excessive regulations and unnecessary paperwork, which greatly increase the cost of providing health care in the current system. The bill would standardize claim forms, preempt state laws which hinder the electronic transmission of claims and other records and provide consumers with information on the comparative value of medical services.

Each of these provisions would streamline the provision of

care in the United States, thus saving providers and consumers millions of dollars every year.

Second, the Chafee/Thomas bill would provide an exemption from antitrust laws to providers who enter into a joint venture to increase efficiencies, expand access, reduce costs and eliminate excess capacity, or share high technology equipment or medical services. Such an exemption, which is more expansive than that included in the President's plan, would enable providers to coordinate efforts to provide the highest quality of care in the most cost-effective manner to all areas of the United States.

Third, the Chafee/Thomas bill would discourage frivolous malpractice claims, limit malpractice awards and eliminate the need for defensive medicine, all of which add unnecessarily to the cost of health care in the United States. This is achieved by requiring the use of an alternative dispute resolution system, capping noneconomic damages, limiting contingency fees, limiting liability to participation in the harmful act and directing punitive damages to the State for the purpose of reducing medical malpractice. Once again, these reforms go beyond those proposed by the President but they go to the heart of the problem and are long overdue.

Fourth, fraud continues to be a growing problem in our health care system. Billions of dollars each year are fraudulently billed to insurance companies and taken from consumers. Current law is not adequate to prevent fraudulent activity.

The Chafee/Thomas bill would enhance the Federal Bureau of Investigation and the Inspector General's office at the Department of Health and Human Services to detect and investigate fraud and the bill protects whistleblowers. The bill also permits private insurers to deny reimbursement to providers who commit fraud, just as the government does, and allows for the forfeiture, after conviction, of property either involved in a health care fraud scheme or obtained with the proceeds of such a scheme. These reforms would greatly reduce health care fraud in the United States, and they can be passed today.

Finally, the Chafee/Thomas bill provides consumers with the option of opening a medical savings account, known as a MediSave account. These accounts would allow consumers to make the health care spending choices they and their doctor believe are most cost-effective. They also reward consumers who use health care dollars prudently by allowing them to rollover any leftover funds in the account to the next year.

The most crucial element to controlling costs in the health care system is to get the consumer more involved. In this assertion we are in firm opposition to the single payer advocates who want access to the tax base to provide care to all with little or no discipline to use the health care system prudently. The current threshold question of "Will my insurance cover the procedure?" must be replaced by informed dialogue between the patient and their doctor about the efficacy and cost of the procedure. MediSave accounts, as well as the cap on the deductibility and excludibility of health insurance premiums, will force consumers to be more informed and participatory in their health care decisions, thus reducing health care costs.

The access and cost control provisions in the Chafee/Thomas bill are designed to address the problems currently found in our health care system, not the ones found in the health care system of the late-1980s. These reforms can be accomplished now, bringing much-needed relief to American consumers, and I urge the Subcommittee to pass this legislation and send it to the President for his signature.

Chairman STARK. I thank the gentleman.

We are pleased now to recognize one member of the subcommittee, two members of the full committee, Hon. Lewis F. Payne from Virginia, and Hon. Fred Grandy of Iowa, and I will let you all decide among you as to which one would like to go first.

STATEMENT OF HON. FRED GRANDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. GRANDY. Mr. Chairman, I lost the toss. So I will go first.

Chairman STARK. All right.

Mr. GRANDY. Mr. Chairman, let me begin by asking the Chair for the opportunity to include a complete text of my remarks in the record of this hearing.

Chairman STARK. Without objection, all witnesses today will have their prepared remarks and any supplemental material appear in the record in its entirety.

Mr. GRANDY. Thank you, Mr. Chairman. I am going to also include an editorial by Robert J. Samuelson in the February 2nd edition of The Washington Post, the title of which is the dishonest and nasty health debate, and I just wanted to begin by reading a paragraph of that, because I think to some degree, we have allowed the debate to overwhelm perhaps some of the substance of our deliberations on health care, but let me just begin with this because I think this is a problem that all of us who are in the health care vineyards right now, whether we support the Cooper-Grandy bill or the Chafee-Thomas bill or any of the alternatives, have to reckon with.

Mr. Samuelson says the following. He says:

Both Clinton and his critics skirt the real problem. Most Americans express far more from the medical system than it can deliver. In general, we think people should have good care when they need it, cost should be no bar, insurance should pay. The issue is a moral one, but naturally we don't want soaring insurance cost to raise our taxes or depress our salaries. All of these are worthy goals, but, unfortunately, contradictory ones,

And that is the point that I think we should begin with here, Mr. Chairman, is the bottom line for lawmakers and politicians who are trying to come to some kind of compromise on this, if indeed we are.

Basically, we have to deal with an American electorate that is all for health care reform as long as we don't change anything, and clearly there is not a bill out there that is not involved in some amount of behavioral modification, and I think that we have to own up at the beginning that if we are going to undertake this kind of social engineering, either in a large degree or a smaller degree, there are some changes that people probably will find objectionable even if they don't fully understand them.

I would point out that when Dr. McDermott was querying the minority leader about his plan, we were again reengaging the debate about whether health care is a right versus a responsibility. I am not sure that debate serves this committee or Energy or Commerce or Education and Labor or any of the committees that will have a large piece of the markup.

I think we all acknowledge if we are in this for the long run, that is, a combination of both and finding the right mix of individual re-

sponsibility, and citizen right to at least access health care is where the compromise will come down.

I would also just also say that no matter whether we are supporters of single payer, a la McDermott-Wellstone, or whether we move to the opposite end of the spectrum and believe that we can solve our health care problems through the Tax Code, like Senator Gramm believes, we are all trying to solve one equation, and that basically is cost plus access to health care plus quality must equal value. If the American doesn't want it, they will reject this compromise as quickly as they rejected the catastrophic bill of a few years back.

So let me begin now with kind of excerpting my testimony, and then I will yield to my colleague, Mr. Payne, who is one of the early cosponsors of the Managed Competition Act.

We are here to provide an overview of the health care legislation, I have cosponsored with a diverse coalition of 57 of my colleagues, including Representative Jim Cooper, who is the author of the bill, and 5 other members of this committee; principally, Mr. Payne, Mrs. Johnson, Mr. Andrews, Mr. Houghton, and Mr. Camp.

The official title of the legislation is the Managed Competition Act of 1993, and it remains the only comprehensive bipartisan health care reform proposal before either body of the House.

As you know by now, Mr. Chairman, the Managed Competition Act is a market-based approach to health care reform. It guarantees universal access to high-quality, affordable health care, and like the President's proposal, the Managed Competition Act builds off of what works in the current system and reforms the chronic problems that have plagued our system for too long. Most importantly, like the President's plan, the Managed Competition Act ensures that every American will have access to a private health care sector plan.

I would like to begin, though, by addressing up front this criticism that has been leveled against our bill about whether or not we are for or provide universal coverage. Everybody who is out here, I think is working toward the goal of universal coverage, and I believe that the universal access mechanism that is embodied in the Managed Competition Act is the best means of achieving that end. In other words, it is the best way to kind of reconcile the public's right to access to health care and an individual's responsibility to purchase it.

So the whole discussion of access versus coverage, I think is a question of semantics. It is more a discussion of timetables and how we get to universal coverage, and the Managed Competition Act uses a different mechanism than the administration to achieve universal coverage, but I believe we share the same underlying goal, and as I am sure you are aware, that goal is now embraced by, among others, the Business Roundtable, National Governors Association, and other groups that have come forward.

Let me talk about some of the specific components in the Managed Competition Act. In many instances, these will correspond to proposals you have already heard today.

One is insurance reforms that will encourage insurers and providers to combine and form accountable health plans. Accountable health plans will not be allowed to exclude coverage of preexisting

conditions and will not be allowed to charge higher rates based on an individual's medical history.

I don't think there is a health plan out there that doesn't do that, but I think we should also be mindful that that alone would raise cost.

Two is access provisions which will ensure individuals' and small businesses' affordable coverage by joining health plan purchasing cooperatives. These cooperatives will offer group rates with lower administrative costs, and once a year, individuals will be able to choose from a menu of AHPs in the area, much like the current Federal Employee Health Benefits plan. As I am sure you are aware by now, those purchasing cooperatives are mandatory for employers with fewer than 100 individuals.

Three is provisions to change the incentives in the system for "more money for more services," fee-for-service, in other words, in which health plans are prepaid, so they will have incentives to promote preventive care, which eliminates unnecessary tests and ineffective treatments, and which reduces administrative costs. Because accountable health plans will be required to provide information on health outcomes and beneficiary satisfaction, they will be driven to improve quality.

The other thing I want to stress here is that for every procedure that you would avail yourself under, under the Managed Competition Act, there would be some kind of copay, no matter whether you are an upper-income individual or somebody just coming off AFDC. The only exception we make here, Mr. Chairman, is for what we consider preventive or wellness kinds of treatment, colorectal screenings, mammograms, immunizations, those we try to create an incentive for by not requiring a copayment. Again, one of the common goals that I think is shared in all of the health care reform proposals is to encourage wellness and preventive care.

Fourth, a Federal low-income assistance program will pay health plan premiums for all people below 100 percent of the poverty level. Individuals between 100 percent and 200 percent of the poverty level will receive sliding-scale subsidies toward the purchase of a health plan. This involves, of course, the federalizing of the acute care portion of Medicaid, and that is one that is, perhaps, more controversial, but I think one of the more attractive selling points of this bill in that we do try and target resources to those people among the uninsured who need it the most, the uninsured, the people who are working for low income, in many cases, minimum-wage employers who up to this point have not been able to access a plan either because their employer does not provide it or if they did they couldn't afford it.

These subsidies will defray those costs and, hopefully, open up a new avenue of accessibility to the people who I think are currently most disadvantaged along with the uninsurable population in society today.

I might say, parenthetically, that is where I really diverged with H.R. 3080. To allow the States the option to just kind of convert Medicaid to this kind of a plan is a good intermediate step, but I think we are beyond that, and I don't think anybody will get up and argue for the viability of continuing Medicaid the way it is, and that is why we attempt to federalize it and turn it into a low-

income subsidy program that, I might say, reaches more deeply into lower-income populations than even the Clinton plan does. The Clinton plan goes to 150 percent above poverty. We go to 200 percent.

Finally, of course, are tax reforms which will allow employers to deduct the cost of the most efficient health plans, but not the cost of excessive benefits or wasteful spending. In addition, individuals and the self-employed will for the first time enjoy 100-percent deductibility of their health plan premiums. Again, this goes beyond the tenets of H.R. 3080.

So, in other words, if I am working for an employer, a small employer, let's say, who provides only 50 percent of my benefit, I can deduct 100 percent of that 50 percent in addition to getting a subsidy if I am a low-income individual. This, I think, is part of the empowerment in H.R. 3222 that provides a new avenue of access to, again, low-income individuals and particularly working mothers in the workplace.

We have, along with most of the other health care proposals, the requisite amount of rural health care, antitrust reforms and malpractice reforms, administration simplification, electronic claims processing. I don't think we need to get into that. There seems to be common agreement on that, although, obviously, malpractice will be slugged out in the Judiciary Committee and not here.

Let me just, again, go back to two points, Mr. Chairman, and that is, first of all, what I mentioned with the Leader. I don't think we are going to get anywhere in this debate unless Republicans and Democrats work together. This is the only bill that at least has a working consensus among House Members. It is the only bill that has at least moved over to the Senate side to work with Senator Chafee and others who support that proposal.

I will point out that when the Business Roundtable endorsed this proposal last week, despite heavy pressure from the White House to stay off, they called it a thoughtful first step, and that is clearly what it is. We do not claim to have developed the final product of this debate. Even cosponsors of this bill, who will testify later, have misgivings about the tax cap, about a mandatory purchasing cooperative as opposed to a voluntary purchasing cooperative. That is all well and good, but to get to the discussion of those issues, I think we have to move beyond the hurdles that the Clinton plan puts before us which are heavy-handed employer mandates, global budgets, and large bureaucracies, none of which are contained in the Cooper-Grandy legislation.

I believe the Managed Competition Act represents the best starting point for the upcoming debate, and this sentiment, as I say, has been echoed now by the Business Roundtable, the National Governors Association, and a broad cross-section of the business community.

With that in mind, Mr. Chairman, I hope that we will be given full consideration not just in the hearing process, but also as we move to markup, and at that point, I would like to yield to my colleague, a member of the committee, Mr. Payne.

[The prepared statement and attachment follows:]

THE HONORABLE FRED GRANDY

U.S. House of Representatives
418 Cannon HOB
Washington, D.C. 20515
(202) 225-5476
February 10, 1994

THE MANAGED COMPETITION ACT OF 1993 -- H.R. 3222
Testimony Before
The House Ways and Means Subcommittee on Health

Mr. Chairman and members of the Committee, I appreciate this opportunity to testify on one of the most important policy decisions confronting the United States Congress. Specifically, ensuring affordable, high quality, health care coverage for all Americans.

Today, I am here to provide an overview of health care legislation I am proud to have cosponsored with a diverse coalition of 57 of my colleagues including Representative Jim Cooper and five other members of this committee: L.F. Payne, Nancy Johnson, Mike Andrews, Amo Houghton and Dave Camp. The official title of the legislation is the Managed Competition Act of 1993. It remains the only comprehensive bi-partisan health care reform proposal introduced in the House.

As you are by now aware, the Managed Competition Act (MCA) is a market-based approach to health care reform. It guarantees universal access to high-quality, affordable health care. Like the President's proposal, the Managed Competition Act builds off of what works in the current system and reforms the chronic problems that have plagued our system for too long. Most importantly, like the President's plan, the Managed Competition Act ensures every American access to a private sector health plan.

I would like to address upfront a criticism that has been leveled against the MCA, that we do not provide universal coverage under our proposal. I want to make it clear that we are not opposed to universal coverage. In fact, universal coverage is a goal that is shared by me and all of the cosponsors. I believe that the universal access mechanism in the Managed Competition Act is the best means to achieving universal coverage. These are not mutually exclusive goals. This whole discussion over access versus coverage is really, in my opinion, an issue of semantics. It is more a discussion of time-tables and how do we get to universal coverage. The MCA uses a different mechanism than the Administration to achieve universal coverage, but I believe we share the same underlying goal. I am here to offer my aid in achieving our shared goal of ensuring that all Americans are covered under a system of health care that provides the quality of care Americans want and deserve.

Our bill uses a series of strong tax incentives that will encourage providers and insurers to form accountable health partnerships (AHPs) which, for the first time, will be publicly accountable. Accountable not only for the cost of the care they provide but also for the quality of that care. This will enable consumers to purchase health care coverage in a much more cost conscious manner than they do today. It will also provide them with the information necessary to truly determine which of the plans available to them provides the highest quality of care.

To help facilitate individuals' and small businesses' access to these new AHPs and ensure affordability, regional purchasing cooperatives will be developed to give individuals and small businesses the benefits of greater buying power currently enjoyed by larger employers. A national Health Care Standards Commission will establish a basic benefits package which AHPs will be required to offer in order to receive tax-favored status. In addition, AHPs will be required to comply with a series of insurance reforms and disclose information on medical outcomes, cost-effectiveness and consumer satisfaction.

Specific components of the Managed Competition Act include:

1) Insurance reforms that will encourage insurers and providers to combine and form AHPs. AHPs will not be allowed to exclude coverage of pre-existing conditions and will not be allowed to charge higher rates based on an individual's medical history;

2) Access provisions which will ensure individuals' and small businesses' affordable coverage by joining Health Plan Purchasing Cooperatives (HPPCs). HPPCs will offer group rates with lower administrative costs. Once a year individuals will be able to choose from a menu of AHPs in the area much like the current Federal Employees Health Benefits Program;

3) Provisions to change the incentives in the system from "more money for more services" to a system: in which health plans are pre-paid so they will have incentives to promote preventive care; which eliminates unnecessary tests and ineffective treatments; and which reduces administrative costs. Because AHPs will be required to provide information on health outcomes and beneficiary satisfaction, they will be driven to improve quality;

4) A federal low-income assistance program will pay health plan premiums for all people below 100% of the poverty level. Individuals between 100% and 200% of the poverty level will receive sliding-scale subsidies toward the purchase of a health plan;

5) Tax reforms which will allow employers to deduct the cost of the most efficient health plans, but not the cost of excessive benefits or wasteful spending. In addition, individuals and the self-employed will for the first time enjoy 100% deductibility of their health plan premiums;

6) A series of provisions and additional resources to assist underserved areas in recruiting and retaining providers, the development of provider networks, integration of public health clinics and coordination with urban medical centers; and

7) Savings mechanisms such as enhanced competition among health plans, anti-trust reforms, significant malpractice reforms, administrative simplification and electronic claims processing.

Mr. Chairman, this committee has heard various approaches to expanding access and ensuring affordable health care coverage for all Americans. These range from proposals that would eliminate the current system and replace it with a Canadian-style system, to proposals that would eliminate the current tax deduction provided businesses for their health care expenses and replace it with an individual tax credit. Our proposal clearly comes in well to the right of the single-payer approach and left of the medical IRA approach. On a spectrum with these two approaches as the respective left and right ends, our proposal comes in on the fifty yard line, building upon the very best aspects of our current system and providing the flexibility necessary to address the deficiencies within that system.

As important as the specific policies included in any legislative framework are the politics involved in building a coalition to pass health care reform. In that regard I submit that the Managed Competition Act provides the foundation for bipartisan reform because it represents a true bipartisan approach to reform. Unlike the single-payer approach, the Administration's proposal, the House GOP proposal, and the medical IRA approach, H.R.3222 remains the only bipartisan approach.

We do not claim to have developed the final product of this debate; only the legislative process itself can accomplish that. We do however have the only proposal that has shown a good faith effort to put aside partisan positioning and work together across the aisle and on both sides of the hill, and as such, I believe the Managed Competition Act represents the best starting point for the upcoming debate. This sentiment has been echoed by the Governors and a broad cross section of the business community.

Thank you once again for holding these hearings and providing me with this opportunity. I would be happy to answer any questions at this time.

Robert J. Samuelson

The Dishonest (and Nasty) Health Debate

A year ago, I held out the hope that we might have an honest health care debate. Perhaps improbably, it hasn't happened. On the one hand, President Clinton's plan is hugely dishonest. It offers almost everything to everybody. It would mandate universal health insurance, control costs, expand Medicare and provide new benefits for early retirees—all without imposing major new taxes, threatening the quality of care, reducing patients' choice of doctors or requiring federal price controls. The only thing it doesn't promise is immortality.

On the other hand, Clinton's critics now declare that the health care "crisis" doesn't exist. This rebuttal is accurate in the sense that the health system doesn't face collapse and provides good care for most people. But the argument is misleading because it wrongly implies there are no serious problems: high costs, spotty insurance coverage and genuine public anxieties about both. Everything won't get better spontaneously.

Both Clinton and his critics skirt the real problem: Most Americans expect far more from the health care system than it can deliver. In general, we think people should be in good care when they need it. Costs should be no barrier to care. We should pay, but not too much. And we should get the best care we can. But rather than try to control or reduce soaring insurance costs to raise our taxes or depress our salaries, all these are worthy goals—but, unfortunately, contradictory ones.

There are no obvious limits to health "needs." If we have all the care we (or our doctors) say we need, costs will skyrocket. So, controlling costs means curbing some treatments or excluding some

diseases or people from insurance coverage—or both. The hard part is weighing costs vs. coverage.

What's missing from this debate is a greater awareness of the conflicts between desirable goals. The warning TV ads have distilled the debate into competing sound bites and nasty scare talk. The insurance industry has Harry and Louise complaining about middle-class government bureaucrats; a pro-Clinton ad reduces anyone who would go "halfway" with reform. The main antagonists don't raise the debate much higher. The president dismisses critics' criticisms as "promising compromises" that will never be "taken away." Meanwhile, Clinton's critics debunk the "crisis," as if there's nothing else to discuss.

The latest twist in this argument is the claim that health spending is slowing on its own. See, say the critics, there's no problem after all. You should treat this concern as a mirage. True, increases in health care prices (measured by the consumer price index) have subsided. In 1993, they rose 5.9 percent, down from 9 percent in 1990. But the increase is still double overall inflation of 3 percent. And the rise in health insurance premiums, though reduced, still outpaces the economy's growth.

Health analyst Jon Gabel of KPMG/Peet Marwick attributes the spending slowdown to four causes: (1) lower overall inflation; (2) efforts by companies to push more workers into "managed care"—health maintenance organizations and similar groups; (3) voluntary price restraint by drug companies and doctors out of fear of federal price

controls; and (4) the "insurance cycle" that creates wide swings in premium changes.

Gabel thinks spending will speed up in a few years as health care technologies, an aging population and high public expectations of medicine. From 1984 to 1990, spending rose 10 percent. In 1984, the Reagan administration claimed that health inflation had been "broken." And indeed, health spending stabilized at 10 percent of the economy's output (gross domestic product) for four years. But then it jumped again; by 1991 it was 13 percent of GDP.

Whatever happens, the spending slowdown has been achieved at the expense of other goals. The number of uninsured has grown. Among the insured, patient choices are shrinking. A Peat Marwick survey of 1,100 companies found, for example, that 58 percent of their workers are now enrolled in "managed care" arrangements, double the 1988 level. Although managed care has advantages (our family belongs to an HMO), loss of choices isn't one of them.

That's the crux of the matter: All our goals can't be met. No health plan can be perfect. All need to be judged against the alternatives, including doing nothing. In its present form, Clinton's plan is worse than doing nothing. It could cause more problems than it solves. Yes, it would provide universal coverage. But it could needlessly disrupt doctor-patient relations, intensify spending pressures and make it so complex and contradictory—spawn massive confusion.

The alternative to Clinton's plan, though, isn't simply to keep government out of health care, as

many conservatives imply. In truth, the biggest player in health care is already the government. It pays two-thirds of all health bills, mainly through Medicare and Medicaid. It heavily subsidizes private insurance, because employer-paid insurance is not taxed as individual income. (That is, your employer pays \$4,000 for insurance for you, but you don't pay taxes on the \$4,000.) The real issue is whether government policies can be improved.

It won't be possible unless we decide what we really want. To control costs? To cover the uninsured? To preserve quality of care? Every problem has remedies. To curb costs, we might impose strict spending controls or end tax subsidies for insurance. But the solution to one problem may aggravate others. Spending controls might undermine the quality of care. Ending tax subsidies would mean Americans would buy less insurance; paying more of their bills, arguably, would make people more cost-conscious. But it might also mean they would receive less care.

Hardly anyone wants to raise these disconcerting choices. There seems to be a presumption that Americans are too dim-witted to grapple with them. The White House started the debate dishonestly; its critics have responded in kind. What we have now is a litigious struggle to win the battle of public opinion. Each side contends that the other government or private medicine can't be trusted with the health care system. It's Public Incompetence vs. Private Greed. The media war is engaging. But as a debate, it sheds more darkness than light.

Chairman STARK. L.F., welcome. Congressman Payne.

**STATEMENT OF HON. L.F. PAYNE, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF VIRGINIA**

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you for giving me this opportunity to testify, and I want to thank you and the members of the committee for all the work that you are doing on behalf of the full committee and on behalf of the Congress in terms of dealing with a very complex and a very important subject, which is how to reform our Nation's health care system.

As the subcommittee considers the various health care proposals before it, I would like to express the importance of seeking a bipartisan solution because I think, in order for us to make health care reform work back home and in order to successfully change the way our country spends \$1 out of every \$7, we must have the support of the entire Nation; that is, Democrats and Republicans and Independents alike. H.R. 3222 is the only health care reform bill before Congress with truly bipartisan support in that 31 of the current 57 cosponsors are Democrats.

Representative Jim Cooper made an important contribution to the health care reform debate when he introduced the Managed Competition Act in 1992, and President Clinton, then running for the presidency, seized upon managed competition in his presidential campaign as the new Democratic approach to health care reform. So the sponsors of managed competition delayed introducing any bill in the 103rd Congress to allow the President to introduce his health plan first. The supporters of the managed competition approach saw that the President's plan had moved away from its managed competition origins and reintroduced the Managed Competition Act. While I very much applaud President Clinton, Mrs. Clinton, and the administration for their tremendous leadership on this issue of health care reform, I cannot support his bill as it is currently drafted.

Last week, the National Governors Association unanimously approved a resolution urging the Congress to pass a health care reform bill this year. This bipartisan resolution called for the establishment of an affordable standard package of health care benefits, the creation of purchasing cooperatives, the provision of subsidies to low-income individuals, limits on tax deductibility of health plans, and insurance and malpractice reforms. All of these recommendations are contained in the Managed Competition Act.

The Business Roundtable, which is a group representing over 200 of the Nation's largest businesses, voted overwhelmingly to support the Managed Competition Act as the starting point for the health care reform debate, and this is not to say that the Managed Competition Act is or should it be the final product of this committee or of this Congress, but, rather, it should be used as the main building block upon which a bipartisan health care reform plan can be constructed.

The Managed Competition Act will build upon existing reforms that are already taking place in the private marketplace, namely by utilizing current innovations in managed care, and managed care plans have grown dramatically in recent years. Enrollment in HMOs has more than quadrupled since the early 1980s. Over 50

million individuals are expected to be enrolled in HMOs by the end of this year. Employers and consumers are choosing managed care because it works, as it provides quality care while it also contains cost.

When you look at the health care reform proposals before this committee, the Managed Competition Act comes closest to the President's plan. There are many similarities, but there are also some key differences. We agree on most goals of health reform, but we disagree on the role that the Government should play in the marketplace. We disagree on employer mandates. We disagree on the bureaucratic price controls and large and bureaucratic health alliances.

The Managed Competition Act promises less than the administration's bill, but we are confident that we can deliver on these promises. If this committee has learned anything from the CBOs analysis of the administration's health care proposal, it is that Congress should tread carefully before creating an enormous new entitlement program.

Mr. Chairman, to conclude, the Managed Competition Act is closer to the President's and closer to the Governors' recommendations than any other bill before the Congress. H.R. 3222 is the only truly bipartisan bill. It is not the final word in health care reform, but it is the best starting point to achieve a national consensus on this very complex issue. With managed competition, we have an opportunity not to copy another nation's health system, but, instead, to create an innovative system that will be the envy of the world.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

Testimony of Representative L. F. Payne

Before the
Subcommittee on Health
Committee on Ways and Means

February 10, 1994

Thank you, Mr. Chairman, for giving me this opportunity to testify before you and the Subcommittee today. I appreciate all the hard work that you and the Subcommittee are doing on the extremely complex and important task of reforming our nation's health care system.

I would like to speak with you today about H.R. 3222, the "Managed Competition Act of 1993". As this Subcommittee considers the various health care reform proposals before it, I would stress the importance of seeking a bipartisan solution. In order to make health care reform work back home, in order to successfully change the way our country spends one dollar out of seven, we must have the support of the entire nation - Democrats, Republicans and Independents alike. H.R. 3222 is the only health care reform bill before Congress with truly bi-partisan support - 26 of the current 57 co-sponsors are Republicans.

Representative Jim Cooper made an important contribution to the health care reform debate with his introduction of the Managed Competition Act of 1992. I am proud to have been an original co-sponsor of that bill. Building upon the framework of a Jackson Hole Group proposal, the Managed Competition Act introduced a new lexicon to the health care reform debate - Managed Competition, HPPC's, and Accountable Health Plans. President Clinton seized upon Managed Competition in his Presidential campaign as the "New Democrat" approach to health care reform.

The sponsors of the Managed Competition Act delayed introducing the bill in the 103rd Congress in order to allow the President to introduce his health plan first. Supporters of the managed competition approach saw that the President's plan moved far from its managed competition origins, and reintroduced the Managed Competition Act. While I applaud President Clinton, Mrs. Clinton, and the Administration for their tremendous leadership on the issue of health care reform, I cannot support his bill as it is presently drafted.

Last week, the National Governors' Association unanimously approved a resolution urging the Congress to pass a health care reform bill this year. This bipartisan resolution called for the establishment of an affordable standard package of health care benefits, the creation of purchasing cooperatives, the provision of subsidies to low-income individuals, limits on the tax deductibility of health plans, and insurance and malpractice reforms. All of these recommendations are contained in the Managed Competition Act.

The Business Roundtable, a group representing over 200 of the nation's largest businesses, voted overwhelmingly to support the Managed Competition Act as the starting point for the health care reform debate. The U.S. Chamber of Commerce, representing America's small businesses, testified before this Committee that because of "high employer premium contributions, rich benefits, and counterproductive regulation and new federal and health alliance bureaucracy", the President's plan should not be used as a starting point for Committee markup.

This is not to say that the Managed Competition Act is, or should be, the final product of this Committee or this Congress. Rather, it should be used as the main building block upon which a bipartisan health care reform plan can be built.

The Managed Competition Act will build upon existing reforms already taking place in the private market place, namely by utilizing current innovations in managed care. Managed care plans have grown dramatically in recent years - enrollment in HMOs has more than quadrupled since the early eighties. Over 50 million individuals are expected to be enrolled in HMOs by the end of the year. Employers and consumers are choosing managed care because it works, providing quality care while containing costs.

A recent study by Peat Marwick indicates that HMO premiums increased 40% less than fee-for-service premiums over the five year period from 1988 to 1993. HMOs also provide a richer benefits package than fee-for-service plans, including preventive health care services such as adult physicals and well-baby care. H.R. 3222 will continue to encourage such cost-saving innovations in the private market place.

When you look at the health care reform proposals before this Committee, the Managed Competition Act comes the closest to the President's plan. There are many similarities, but there are also some key differences. We agree on most of the goals of health reform, but we disagree on the role that government should play in the market. We disagree on the employer mandates, bureaucratic price controls, and large and regulatory health alliances.

The Managed Competition Act promises less than the Administration's bill, but we are confident that we can deliver on those promises. If this Committee learned anything from the CBO's analysis of the administration's health proposal, it is that Congress should tread carefully before creating an enormous new entitlement program.

To conclude Mr. Chairman, the Managed Competition Act is closer to the President's and closer to the governors' recommendations than any other bill. H.R. 3222 is the only truly bipartisan bill. It is not the final word in reform, but it is the best starting point to achieve national consensus on this complex issue. With managed competition, we have an opportunity not to copy other nations' health systems, but instead to create an innovative, new system that will be the envy of the world.

Chairman STARK. Thank you, L.F.

Next on our list is Hon. Nancy Johnson. Welcome.

STATEMENT OF HON. NANCY L. JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mrs. JOHNSON. Thank you, Mr. Chairman.

I will be fairly brief because there are two things I want to say. I think in our sober moments, we all recognize that this health care reform ought to be bipartisan. First of all, it is not fundamentally a partisan issue, but, also, the people expect that we think far more seriously about their problems and that we relate changes in law more directly to their problems than is possible if ideology takes precedence over practical reality.

Consequently, I am proposing in my bill that we are hearing before this committee a piece of the solution because I think that we are going to have to build this solution and look at the individual integrity of each piece and then the integrity of how all the pieces interrelate. So my proposal would fit into the Republican proposal. It would take their collective purchasing provisions and bring them a step further by requiring that every State put in place a purchasing cooperative.

It would fit within the Cooper-Grandy proposal, making their mandatory purchasing cooperative voluntary; therefore, making it more comfortably applicable, particularly in rural areas, giving us the chance to build what we will need before we make any decision as radical as demanding that a large percent of the population participate through one kind of entity.

While the Cooper-Grandy bill does bring down the number of people that have to buy through the entity from 1,000 to 100, an employers with fewer than 100 are 98 percent of the employers in Connecticut. So it is still a pretty good whack.

My bill is already included in the Chafee-Thomas bill, although it appears in various fragments. I have pulled it out, worked through it very thoroughly with experts, and I present it to you today.

The legislation that I have introduced, H.R. 3652, would require that each State create at least one purchasing cooperative, but it allows multiple competing purchasing cooperatives because some of those that have tried to get started have turned out not to be very good. Like anything else, it depends on good management, creative leadership, and a good purchasing cooperative. It is going to be different than a poor purchasing cooperative.

So my bill does allow multiple competing purchasing cooperatives in which individuals and small employers can freely enroll and select from a wide array of competing health plans. Each of these plans would be required to provide the standard benefit package consistent with the insurance reform proposals that we are all in pretty good accord about.

Additional provisions of my bill would require that the individuals and small employers that purchase through the HPPC have the choice of at least three different plans. So the purchasing cooperative would have to provide at least a managed care option, a fee-for-service option, and a medisave option.

I think this latter issue is particularly important. I think when we are talking about real reform—and clearly, one of the things that has driven rising costs has been overuse of the system—I think it is important that we experiment with bringing individuals into the decisions about purchasing health care for their own purposes; in other words, their own wellness.

I think it is also legitimate and reasonable for a nation that undersaves and that has enormous concerns, at least if you read the numbers. You ought to have enormous concerns about whether the baby boom generation is going to enjoy retirement security.

We ought to be allowing our people and encouraging them to use vehicles like medisave, so that they not only think about health care purchases, but can roll any money they save over into a retirement vehicle, again, looking at long term costs, and personal security in a larger setting.

Second, the bill requires that all health plans sell their products for the same price within the HPPC and without the HPPC between the insurance reform provisions that reduce the right to risk select. In this price comparability inside and outside of the HPPC, we have reason to believe that there will be minimal risk selection, although the bill does require insurance commissioners to watch this issue and gives insurance commissioners really quite broad powers to address it, should it develop.

The bill also provides an assurance that all plans would comply with proposed insurance reforms, including guaranteed availability, renewability, and continuity of coverage, limits on the use of pre-existing condition exclusions, and modified community rating.

The Health Plan Purchasing Cooperative would enable members of the cooperative to benefit from the cooperative's contracting expertise, the administrative savings that accrue from large pools, the elimination of marketing expenses which are very high in the small group market, and the consumer information that HPPCs would compile in the plans offered through them. Like the managed competition framework within which this proposal could easily operate, H.R. 3652 would encourage competition, increase access, bring down costs, and improve quality.

Thank you for this opportunity to appear before the committee today and to be part of a panel from which many of the ideas that will be part of the solution will come.

Thank you, Mr. Chairman.

[The prepared statement follows:]

NANCY L. JOHNSON
6TH DISTRICT, CONNECTICUT

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE:
HEALTH
TRADE

COMMITTEE ON
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TESTIMONY OF CONGRESSWOMAN
NANCY JOHNSON
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

FEBRUARY 10, 1994

Mr. Chairman and members of the Committee, it is a pleasure to be here today to discuss alternative approaches to health care reform. It is my sincere hope that on this important issue we will be able to put aside partisan politics and work together to craft a bipartisan reform package of which we can all be proud. In that regard, I am happy to have the opportunity to describe a bill I introduced in the last session of Congress which I believe is applicable to any of the reform proposals that rely upon the managed competition framework. In fact, my proposal is applicable to any plan which uses purchasing pools as a mechanism to ensure access to more affordable insurance for those in the individual and small group markets.

The legislation I have introduced, H.R. 3652, the Health Plan Purchasing Cooperative Act of 1993, provides a framework for the creation of purchasing cooperatives. Under my proposal, states would establish voluntary Health Plan Purchasing Cooperatives (HPPCs) in which individuals without insurance and small employers could freely enroll and select from a wide array of competing health plans. Each of these plans would be required to provide a standard benefit package consistent with the insurance reforms which have wide bipartisan support on both sides of the Hill.

Additional provisions of the Health Plan Purchasing Cooperative Act include:

- * A specification that all individuals and small employers purchasing insurance through the HPPC have access to at least three standard plan choices -- a managed care plan, a fee-for-service plan, and a medisave plan.
- * A requirement that all health care plans sell their products for the same price both inside and outside the HPPC so that neither the HPPC plans nor plans outside the HPPC receive an inequitable share of risk.
- * An assurance that all plans would comply with proposed insurance reforms including guaranteed availability, renewability and continuity of coverage, limits on the use of pre-existing condition exclusions, and modified community rating.

The Health Plan Purchasing Cooperative Act also would enable the members of the cooperative to benefit from the cooperative's contracting expertise, the administrative savings that accrue from larger pools, and the consumer information they would compile on the plans that offered insurance through the HPPC. Like the managed competition framework within which this proposal is intended to operate, H.R. 3652 would encourage competition, increase access, bring down costs and improve quality.

Thank you for giving me this opportunity to appear before the Committee today. I look forward to working with you to develop a health care reform package we can enact before the end of this session.

Chairman STARK. Thank you.

We are now pleased to start the testimony from nonmembers of the Ways and Means Committee. So we are happy to recognize Hon. Cliff Stearns.

Mr. GRANDY. Mr. Chairman, we have a member of the committee who is not testifying.

Chairman STARK. You wanted to wait until the end.

Mr. STEARNS. Yes, sir. I will be brief.

Chairman STARK. At the request of Mr. McCrery, he had asked to be the wrap-up. I was going to recognize Mr. Stearns.

I believe, Rod Grams, you are testifying with Mr. Stearns. Is that correct?

Mr. GRAMS. That is correct, Mr. Chairman.

Chairman STARK. So I will let you two proceed in any manner that you care to, whoever chooses to go first.

STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. STEARNS. Thank you, Mr. Chairman. We are delighted to be here.

Chairman STARK. Welcome to the committee.

Mr. STEARNS. Senator Nickles wanted to also testify, and he could not be here. He was here earlier. He asked that I make his statement, as well as Congressman Jim Ramstad, as well as mine part of the record.

Chairman STARK. Without objection, all of the statements will appear in the record in their entirety.

Mr. STEARNS. Mr. Chairman, when President Clinton highlighted his State of the Union statement, he mentioned that he would veto any health care reform legislation that did not contain universal coverage.

On our side of the aisle, our bill, the Consumer Choice Health Security Act of 1993, does include universal coverage. Mr. Chairman, this particular bill has been scored by an outside accounting firm, Lewin-VHI. It has analyzed this for a long period of time. It is deficit-neutral. There are no mandates, no new taxes. In the sense that the Clinton plan provides more bureaucracy, this is no new bureaucracy.

You and I have talked a little bit about the idea of mandates on the employer and mandates on the individuals. This particular plan does have individual requirements that everyone have health care.

Now, we have patterned this plan off of something that is in existence. As many of my colleagues know, we had the Federal employee health benefits program. That has been in existence for 33 years. There are 10 million Government employees involved with this program, and, of course, the President, the Vice President, the Senators, and all the Congressmen are all covered under this plan.

So, Mr. Chairman, I suggest we give this plan to the American people. The American people would have the same options that I did when I came to Congress. I could select 35 different plans and make my decision, and I made the choice.

What we do under our Health Care Security Act is provide legislation which provides a Federal tax credit that would for the first

time give individuals control over their health care dollars. The credit would offset the cost of premiums, out-of-pocket medical expenses, and exempt-from-taxes contributions to medical savings accounts. Now, this is a very simple concept, and it moves in the direction for America to give personal responsibility to individuals and give them the choice.

Now, let me just quickly and briefly give you an example of how this would work. Let's take, for example, that a person who is making \$35,000 a year and the employer pays for their health insurance and it turns out to be roughly \$3,500 a year. Let's say, also, they have out-of-pocket expenses of \$1,000. We will put that into the mix, too. So the individual has \$35,000 in salary, and they have provided by the employer \$3,500 in medical insurance. What our bill would do is move that \$3,500 to the individual with a raise in salary to \$38,500. They would be able to write off their \$3,500 as well as their \$1,000 out-of-pocket expense and get tax relief for out-of-pocket expenses.

The new tax credit established for this family would see their tax liability decrease. They would have more disposable income. Across the board, Lewin-VHI has studied this, and I can give you the information. Part of it is going to be part of our statement. We have shown across the board this provides better tax relief for Americans. Plus, it moves as we know the responsibility for individuals and away from a third payer.

Mr. Chairman, we buy our automobile insurance this way. We buy our life insurance. We buy our mortgages. Why not health care? Why do we delegate the responsibilities for health care to the Government, to the bureaucrats, and force it, mandate it on employers?

It should be pointed out that the idea of employer-provided benefit did not evolve out of the Congress. Instead, health benefits were offered as an incentive to attract employees during World War II when wage controls were in place. Later, the Internal Revenue Service decided that such benefits would be exempt from Federal income and Social Security taxes. These events, among others, have contributed to the current system we are confronted with today.

Our bill opens up competition by providing opportunities for even unions, colleges, farm organizations, and even churches to provide alliances. So, instead of 10 million Americans going out to seek employment, insurance for themselves through the employee benefits program, you would have all American competing in the same way.

As I mentioned earlier, this is the only plan on my side of the aisle that had been scored by an outside accounting firm. We are just getting the CBO estimates now, and, of course, there are no new taxes, no rationing, and no price controls. Again, we have universal coverage.

In conclusion, Mr. Chairman, these are the fundamental concepts. It is not hard to understand. After all, you don't hear many of us here in Congress at this table or in this hearing complaining about their health care coverage.

[The prepared statement of Representative Stearns and the statements for the record of Senator Nickles and Representative Ramstad follows:]

OPENING STATEMENT
by the
HONORABLE CLIFF STEARNS (R-FL)

Testimony before the House Subcommittee on Health
Committee on Ways & Means

February 10, 1994

Thank you Mr. Chairman for allowing me this opportunity to testify before your subcommittee on H.R.3698 / S. 1743, the Consumer Choice Health Security Act of 1993, legislation I jointly introduced with Senator Don Nickles of Oklahoma. As the members of this committee are aware, the issue of health care reform has remained at the forefront of our citizens' concerns and rightfully so. In the President's State of the Union address we all heard him say that he would not sign into law a health care reform proposal that did not guarantee universal coverage. H.R. 3698 does that and more. As such, I believe that it merits full consideration by the Congress before a final bill is brought to the House floor for a vote.

I would like to quote the President from his State of the Union remarks.

"The American people provide those of us in government service with terrific health care benefits at reasonable costs. We have health care that's always there. I think we need to give every hard working, taxpaying American the same health care security they have already given us."

Mr. Chairman, members of this committee, over 40 of our colleagues here in the House and Senate agree with that statement. That is why we introduced the "Consumer Choice Health Security Act of 1993." As the title indicates, this legislation seeks to provide quality necessary medical care to all Americans through the oldest and proven mechanism -- the free market. Furthermore, this legislation is patterned after the Federal Employee Health Benefits Program (FEHBP) that has been in existence for over thirty years and held down costs while providing quality health plans.

As you know, all members of Congress, our staffs, the President, the Vice President, the cabinet, the Supreme Court Justices, and some ten million federal employees, retirees and dependents are enrolled in the FEHBP. The program is unique in that it is explicitly based on the free market principles of consumer choice and market competition.

Unlike our constituents, we have the luxury of being able to pick and choose from over thirty different health plans -- be it a traditional fee for service, HMO, PPO, or union sponsored plan like the postal workers etc. Unlike the rest of America, we get to make a personal choice and compare the prices, and level of benefits of each plan. We then make a decision based on our budget, our needs, and our bottom line, not some corporation's bottom line.

While the FEHBP model is not perfect, with the modifications that have been added in this bill, an FEHBP type system can be expanded to cover all Americans. Combined with an individual mandate that is explicitly written into this bill, the President's goal of universal coverage is met. The FEHBP is a sound program with good benefits. And while the level of benefits has increased over the years, costs for these plans have been effectively kept down. Not with price controls mind you. But with competition. On September 14, 1993, Jim King, the Director of Office of Personnel Management stated "Our enrollees continue to gain from the competition and managed care that form the backbone of the FEHBP program." This is evidenced by the fact that the price of premiums federal employees have to pay in 1994 are only 3% higher than the prices they paid in 1993.

In short, the market forces have worked for the FEHBP. There is no reason why these same principles cannot work for the American people. Most Americans are kept out of the picture when it comes to purchasing health insurance because it is usually purchased by their employer. Doctors and hospitals rarely discuss bills or fees prior to delivery of care and rely on third party reimbursement. Consumers are shielded from the true costs of health care and as such, there is no incentive for all parties involved to control costs. The time old saying of supply and demand -- the market forces that control costs in every other sector of the American economy are not present in an employer based health care system.

In sharp contrast to government based insurance or mandatory employer based insurance, where government bureaucrats or corporate officials are deciding what level of benefits Americans will receive, H.R. 3698 will provide every American with the means to purchase health insurance within the framework of the free market and consumer choice.

Under the Consumer Choice Health Security Act of 1993, health insurance benefits will be made available to all Americans along with

the tax relief currently enjoyed by individuals with employer provided insurance. However, this coverage will no longer be dependent on employment status. Furthermore, consumer choice would serve as a driving force in bringing down costs the same way it does in the rest of the economy. This would be accomplished by transferring the multi-billion dollar federal tax break for employers providing health benefits, in the form of deductions and exclusions - and giving that money to American workers in the form of a federal tax credit. The federal tax exclusion alone was worth \$66.6 billion in 1991 dollars for 1992.

As the members of this committee are aware, this legislation imposes a mandate on individuals to purchase at a minimum, a health care package which must include catastrophic coverage to address the free rider problem. Every individual who fulfills this legal requirement will receive a federal tax credit to offset the costs. This new tax relief would also be extended to individuals and families for payment of out-of-pocket medical expenses. The tax credit will be provided directly through the tax withholding system or through a voucher for the working poor. The size of the tax credit will vary according to a percentage of health care expenses in relation to an individual's

adjusted gross income.

By giving every individual the same tax advantages, irrespective of place of employment or income, and empowering them with tax credits to purchase insurance, a consumer choice system will enable Americans to seek the best value for their health care dollar when buying health insurance. If private employers wish to continue providing health benefits to their employees, there is nothing, I repeat, there is nothing, in this legislation that would prevent them from doing so and they can still continue to deduct the cost of providing that benefit. However, it should be noted that with equal tax treatment for all Americans who purchase health insurance, company plans will be competing with different types of health insurance packages and keep prices down.

At the risk of sounding redundant, I would like to emphasize that the core problem of our current health care system is the tax code, and if we are to ever remedy the problems arising out of the current inequity, the tax code needs to be changed. By changing the tax code and empowering the individual directly, the health care market will be changed from an employer based market to an individual based

market as it should be. By giving the American people what you and I as Members of Congress enjoy, the power to choose our own health insurance plan, and combining that power with widespread competition, H.R. 3698 will offer our constituents the best chance at controlling health care costs.

I would like to point out that this legislation has already been scored by Lewin-VHI, the same health econometrics firm used by the Clinton Administration. It is budget neutral, deficit neutral, and does not raise taxes on Americans. No price controls are employed, no global budgeting, no new bureaucracies are created, and no monopolistic alliances are set up under the purview of a National Health Board.

The major objection I have encountered to an individual mandate is that our citizens aren't capable of choosing their own health plan. I couldn't disagree any stronger. Even Alain Enthoven, one of the architects of "Managed Competition", a proposal that has been offered by our esteemed colleague from Tennessee, Mr. Cooper, has stated the following, and I quote:

"Critics of the consumer choice position usually are not very explicit

about whom they consider to be better qualified than the average American to choose his health plan for him."

- New England Journal of Medicine (1978)

I should point out that Americans make important decisions every day without delegating those responsibilities to government bureaucrats or politicians. They make decisions with respect to their mortgage policies, car insurance policies, life insurance policies, homeowner's insurance policies all without the creation of alliances, national health boards, or bureaucrats. Why? Because these matters are not employer based. When an individual loses his job, he does not lose his car insurance or go to a new mortgage company. There is no reason why health insurance should be treated any differently.

While the changes to the tax code are the heart of this proposal, Senator Nickles and I have included several other key reforms which must be addressed in this debate. Anti-fraud measures are included to enhance federal criminal penalties established against health care providers and insurers who knowingly defraud persons in connection with a health care transaction. Anti-trust provisions have been included to create "safe harbors" from federal anti-trust laws for certain groups of providers; medical self-regulatory entities that do

not operate for financial gain, certain joint ventures for high technology and costly equipment and services and hospital mergers. This is especially crucial for rural area hospitals forced to compete against each other for patients. In my district down in Florida, there have been instances in which a hospital will decide to purchase an MRI machine just so that it can advertise to the public that they have state of the art technology when just a few miles away, another hospital will have the same equipment already in place that could be used by the patients of that first hospital.

Long term care is addressed as well in this bill. H.R. 3698 also exempts from taxation certain exchanges of life insurance policies for long-term care policies, and amounts paid or advanced from a life insurance contract to a terminally or chronically ill individual who is confined to a hospice or nursing home.

Malpractice reforms are also included. The bill caps noneconomic damages at \$250,000, reduces the amount of damages paid in a medical malpractice case by the amount of other payments (such as private disability insurance or employer wage continuation program payments) made to the injured party for medical care, limits the

liability of manufacturers or sellers of health care products approved by the FDA, except in cases where the manufacturer withheld or misrepresented information to the FDA or bribed an official, and provides for a schedule of limits on attorney fees in medical malpractice actions:

1) 40% of the first \$50,000, 2) 33.3 % of the next \$50,000, 25% of the next \$500,000, and 15% of any additional award or settlement.

Mr. Chairman, this provision may sound familiar because it is patterned after California medical malpractice law, also known as (MICRA). This law has been in effect since the mid 1970's and proven to bring down the number of frivolous claims while ensuring the residents of California who are harmed by a negligent doctor to be justly rewarded.

Administrative reforms are also included which are designed to reduce the amount of paperwork and double-billing the insurance industry and hospitals are famous for. Another important feature of this legislation is the explicit pre-emption of state laws which are deemed to be "anti-managed care" laws. For example, the bill would preempt state laws which:

1) require health insurance policies to cover specific diseases,

services, or providers;

2) limit the ability of managed care plans to selectively contract with health care providers;

3) limit the ability of managed care plans to impose higher cost sharing provisions on treatment obtained from providers outside a plan's network.

In conclusion, this legislation achieves universal coverage, provides portability, security, simplicity, and cost containment without raising taxes or the creation of powerful and potentially monopolistic alliances. Instead, it will allow all Americans a wide array of choices of benefits within many health plans, just like the system that is currently available to Administration officials and Members of Congress. The major cost constraint is a purely competitive health care market, something that has been sorely missing for the past five decades. Combined with personal responsibility and the security of knowing that they can purchase health insurance from plans they trust, such as their union, church, farm bureau, or employer, AND enjoying tax relief, this is an alternative that Americans will want to explore further.

As Members of Congress we have been presented with an historic opportunity to rectify what is wrong with the health care system, and to maintain what is right. There is no need to subject one-seventh of the nation's economy to a new and untried scheme that has not been proven to hold down costs while continuing to provide quality medical care to our nation's citizens. We can resort to price controls, decisions coming down from bureaucrats in Washington, DC, and rationing. Or, we can open up the market and give every American the same benefits of choice and competition that Members of Congress enjoy.

Finally, if this Congress fails to give the American people the same benefits and advantages of a free market system of health care, then this Congress should be willing to deny themselves those same advantages and withdraw themselves from a market driven federal system - and enroll in whatever state run health program we force upon the rest of America. Thank you, Mr. Chairman.

STATEMENT BY SENATOR DON NICKLES

HOUSE WAYS AND MEANS COMMITTEE

FEBRUARY 10, 1994

Mr. Chairman, and Members of the Committee, I am pleased to appear before you today along with Rep. Stearns to discuss the Consumer Choice Health Security Act.

In the debate over health care reform, a fundamental choice has emerged: Who should drive health care reform? The government and its bureaucrats? Or consumers, empowered with more control over health care choices and costs?

The President's plan relies on more federal control and regulation of a trillion-dollar industry that represents one-seventh of our entire economy and provides the highest quality health care in the world.

The Clinton plan outlaws virtually all current plans and substitutes a one-size-fits-all program which forces consumers into government controlled monopolies called "health alliances."

Overpromised and underfinanced, the Clinton plan contains

onerous employer mandates and will cost hundreds of thousands of jobs.

But simply criticizing the Clinton plan is not the solution. Those who believe as I do that the Clinton plan would be a disaster are obligated to come up with a better one. That's why 25 of my colleagues in the Senate have joined me in sponsoring the Consumer Choice Health Security Act.

Our program comes down on the side of individuals. It provides universal health care coverage for all Americans earlier than the Clinton's plan, preserves the health choices Americans now have and that the Clintons will take away and provide new opportunities for health care that the Clintons deny; all without increasing taxes or creating new bureaucracies.

The Consumer Choice plan offers all Americans choices much like those found in the highly successful Federal Employees Health Benefits Program (FEHBP) which for 33 years has served nearly 10 million federal employees and their families by offering dozens of

plans which provide a wide array of benefits at a variety of costs.

The FEHBP has worked well for all federal employees, including Senators and Congressmen and our office staffs. We choose our health insurance plan based on what's best for us and our families just as we choose our auto insurance, home insurance and life insurance.

This array of choices has kept premium increases in the FEHBP, on average, one-third less than the national average increase in private health insurance premiums.

Our proposal lets employees keep the health care coverage they now have with their employers if they wish. But could shop for a new plan if they choose.

Here's how it works:

The tax exclusion for company-sponsored health plans would be replaced with individual tax credits. Companies would take the money they spend to subsidize their employees' health insurance and give it to employees in the form of wages. Then, a tax credit would

be given to individuals.

The combination of higher wages and a tax credit would give individuals the resources to purchase the health insurance they want and need. They could keep the company plan, or choose something different. They could also invest some of their resources in tax-free Medical Savings Accounts, using the funds they save to pay for additional health benefits or to save for long-term health care needs.

The choice is theirs.

The tax credits, which would become available on Jan. 1, 1997, would be structured to give all Americans a basic level of tax relief based on all of their health care expenses. Using a sliding scale system, greater tax relief would be targeted to individuals and families who, because of illness or below average incomes, face proportionately higher health expenses relative to their income.

The tax credit would also be refundable so unemployed and poor individuals would be reimbursed for a substantial portion of the cost of their insurance premium. Low-income people also would be

eligible for subsidies in addition to these tax credits.

Best of all, people would get the tax credit for all of their out-of-pocket health care spending-not just for health insurance premiums.

The Consumer Choice health care plan guarantees that all health plans are fully portable. Because individuals own their own policies, they could take them along when they change jobs. No individual could be turned down because of a preexisting health condition. No one could have coverage cancelled or premiums increased because of illness. All Americans would be required to carry a policy that limits their expenses for health care.

Any viable health care reform must address other causes of spiraling costs. Our plan tackles runaway medical malpractice costs by capping punitive damage awards and limiting attorney fees. We also cut red tape and government waste by streamlining health insurance claims and easing regulatory burdens on providers.

Perhaps the greatest savings in total outlays for health care will

result from a very simple but very important change which is fundamental to our plan: Consumers will be spending their own money, not their company's money or the government's money. As a result, consumers will make a fundamental shift in their buying habits which are now often costly because of the perception that "it's not our money we're spending".

But just as important as what the plan will do, is what it will not do, especially when compared with the Clinton government-is-the-answer plan. Because it contains no onerous mandates that force employers to cough up additional dollars for health care plans they cannot afford, it will not cost jobs.

Our plan will not add to the total cost of health care, nor to the federal deficit. It does not include the President's global budgeting which would inevitably result in price controls, ever-increasing regulation, and rationing of health care by bureaucrats.

Health care reform is a complex issue. It's wrong to think that the problems we face in health care can be solved by the kind of

invasive big-government surgery proposed by the Clinton administration. The Consumer Choice plan seeks a straightforward solution by protecting what is right about the current system -- quality and choice -- and knocking down the barriers that deny any American access to affordable health care.

S. 1743

CONSUMER CHOICE HEALTH SECURITY ACT

FACT SHEET

November 20, 1993

Sponsors (25): Nickles, Hatch, Mack, Bennett, Brown, Burns, Coats, Cochran, Coverdell, Craig, Dole, Faircloth, Grassley, Gregg, Helms, Hutchison, Kempthorne, Lott, Lugar, Murkowski, Simpson, Smith, Stevens, Thurmond, and Wallop.

WHAT IT DOES

The Consumer Choice Plan

- Provides the security of universal health care coverage for all Americans, guaranteeing them access to insurance that is portable, and available regardless of pre-existing conditions. It would take effect on January 1, 1997.
- Provides individuals and families with a maximum choice of health insurance plans with a wide variety of benefits and costs, including the ability to keep the employer-sponsored benefits they have now. That's more choice than most Americans have now.
- Individuals and families are provided with the resources to purchase the health insurance plan that best fits their needs with tax credits in place of the current employee tax exclusion for health care expenses. People whose health expenses consume a larger percentage of their incomes would get a bigger tax credit.
- Controls rising health care costs by empowering consumers with choice and individual responsibility and infusing real competition between insurance companies for the consumer's health care dollar.
- Further reduces rising health care expenses with real reform of medical malpractice laws, including capping awards for noneconomic damages.
- Creates Medical Savings Accounts, or MSAs, which can be used to pay medical bills or to pay for extra benefits.

- Modeled after the 33-year-old Federal Employee Health Benefit Program (FEHBP), giving consumers the same option of choice now enjoyed by U. S. Senators and Representatives. The FEHBP's annual cost increases have averaged a third less than other private health insurance programs.

What it does NOT do

- The plan has no new, job-killing mandates on employers to provide and pay for health insurance for their employees. Employers must only give their employees the option of retaining their current benefits, or "cashing out" their benefits and joining another plan.
- The plan requires no new taxes.
- The Consumer Choice and Health Security Act does not wipe out existing health insurance policies, unlike the Clinton plan, which would outlaw nearly every health insurance plan now in existence. Under the Consumer Choice Act, people who are happy with their employer-sponsored coverage can keep it.
- The plan places no price controls or "premium caps" on insurance plans that could reduce the quality of coverage and even result in the rationing of health care.
- The plan creates no new national health board or government bureaucracies.
- There is no government coercion to purchase benefits not wanted or needed, beyond a minimum catastrophic insurance requirement.

HOW IT WORKS

Insurance Reforms to Guarantee Access

- The Consumer Choice and Health Security Act provides for guaranteed issue of health insurance policies. Insurers could not exclude coverage of any preexisting medical condition of any applicant who switches from one insurance plan to another or of any currently uninsured person who buys insurance.
- Insurers cannot cancel or refuse to renew coverage of a health insurance policy except for non-payment of premiums or fraud or misrepresentation. Insurers could not offer bonuses to brokers for selling insurance to "healthy" people or avoiding the sale of policies to

- Health insurance underwriting would be limited, allowing insurers to vary premiums only on the basis of age, sex and geography. However, because of the importance of prevention and healthy lifestyles, the legislation would allow insurers to give incentive discounts to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of illness.
- Certain state laws pertaining to mandated benefits and services, anti-managed care laws, and mandated cost-sharing would be preempted.

Tax Credits

- Individual tax credits would replace the current tax exclusion for company-sponsored health plans.
- Tax credits, which would become available on January 1, 1997, would be structured to give all Americans a basic level of tax relief on all of their health expenses, with greater tax relief targeted to those individuals and families who, because of illness or below average incomes, face proportionately higher health expense relative to their income. The credits would be structured as follows:

Health Insurance Premiums and Unreimbursed Medical Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10 percent	25 percent
10 to 20 percent	50 percent
20 percent or more	75 percent

- At a minimum, for every \$100 which is spent on health insurance premiums, or contributed to a Medical Savings Account (MSA), or spent on ANY out-of-pocket medical expenses, the individual or family would pay \$25 less in taxes. The greater the ratio of health costs to income, the greater the tax benefits. Low-wage persons with higher percentage health costs would receive greater benefits. The tax credit would be as much as \$75 per \$100 spent on health care, and would be refundable as explained below.
- The credits are refundable, meaning that if the value of the credit is more than an individual's or family's tax liability, the government would pay the difference. Much like the treatment of the Earned Income Tax Credit (EITC), employers would reduce their tax liability and provide the tax credit as additional income in the employees' paycheck, so they could purchase insurance.

Family Security Benefit Requirements

- Society should not have to pay the price for irresponsible individuals who refuse to purchase insurance and then expect us to pick up the tab when they become seriously ill or injured. Every individual and family would be required to have minimum health insurance coverage to cover medically necessary "acute medical care," including:
 - Physician services
 - Inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization
 - Inpatient and outpatient prescription drugs
 - A maximum deductible amount of \$1,000 for an individual and \$2,000 for a family and an out-of-pocket limit of \$5,000. These amounts would be indexed to inflation in future years.
- For Medical Savings Accounts, or MSAs, the Consumer Choice plan would provide the same basic 25% tax credit for deposits. Each household would be permitted to have one MSA and to make an annual deposit no greater than the sum of \$3,000 plus \$500 for each dependent. The funds in an MSA could be used to pay medical bills not covered by their insurance plans, and to pay health insurance premiums.
- Transitional Rules: In order to provide individuals and families with secure, portable benefits, insurers and employers who currently provide health insurance coverage would be required to offer policyholders the option of converting their existing coverage to an individual or family plan. Employers would also be required to add the value of the coverage they now offer to their workers' wages. Thus, workers could take their coverage with them when they changed jobs or could use the money to buy a different plan that better suited their needs.

Employer Provisions

- Individuals and families could still purchase health insurance through their employers. This would not be their only option, since they would be able to receive the same tax relief if they purchased coverage on their own or through other groups such as unions, churches, farm bureaus, business coalitions, professional associations, or through some other group — similar to the choices that more than 10 million Federal employees, retirees and their families have today.
- To ensure that individuals and families are able to make regular premium payments on their health insurance, employers would be responsible for withholding premiums from their employees' paychecks and sending these premiums to the employees' chosen insurer. Employers would also be responsible for adjusting their workers' tax withholding to

reflect the new tax credits. Thus, taxpayers would not need to wait until they filed their tax returns to claim back the new tax credits.

- Individuals who fail to enroll in private health insurance plans would be ineligible to claim the personal exemption on their federal income taxes. Employers would adjust their withholding to reflect this increased income tax liability.

Financing the Consumer Choice Plan

- Because the Consumer Choice tax credit is more generous than the tax deductions and exclusions that it would replace, it will result in a net revenue loss to the federal government of \$133 billion between 1997 and 1999. To offset this revenue loss, the bill calls for savings in the Medicare and Medicaid programs of \$139 billion over five years.
- Federal Medicaid payments to states for acute care would be distributed on a per capita basis beginning in fiscal year (FY) 1995. The capitated amounts would be set at 20 percent above the FY 93 level in FY 95. In subsequent years, the capitated payment would rise by one percent above the consumer price index (CPI). Total federal Medicaid acute care payments to a state for FY 95 could not exceed the payment for FY 93 plus 20 percent. In subsequent years, the total federal acute care payment to any state could not exceed the previous year's payment plus CPI plus 2.5 percent. This will produce a five-year savings of \$72 billion. States would be given broad latitude in how they deliver acute medical care services to their Medicaid population.
- Medicare savings will be achieved by eliminating payments to "disproportionate share" hospitals, reducing payments to hospitals for indirect medical education costs, continuing the transition to a prospective payment system (PPS) for outpatient services, and by updating PPS payments on January 1 of each year, rather than on October 1. Further savings would be achieved by placing a 20- percent coinsurance requirement on laboratory and home health services. These changes will save the Medicare program \$67 billion over five years.

Comparison of Savings Achieved The President's health plan and the Consumer Choice plan

Program	Consumer Choice	President
Medicare	\$67 Billion	\$152 Billion
Medicaid	\$72 Billion	\$225 Billion

Cutting Costs through Malpractice, Paperwork Reforms

- The Consumer Choice plan would place a \$250,000 limit on noneconomic damages, provide for periodic payment of malpractice awards that exceed \$100,000, and limit the liability of a defendant for noneconomic and punitive damages to their percentage of fault, as determined by the trier of fact. It would also cap attorney fees, provide for offsets from collateral sources, and set forth rules for any health care malpractice claims filed in state or federal court or resolved through arbitration.
- The Secretary of Health and Human Services would have the power to require all health care providers to submit claims to health insurance companies in accordance with standards developed by the Secretary, if providers are not voluntarily complying with the standards. The Secretary is also directed to adopt standards relating to data elements for use in paper- and electronic-claims processing of health insurance claims, uniform claims forms and uniform electronic transmission of data.

Helping the Disadvantaged

- The Medicaid Disproportionate Share program — now used to reimburse providers to help defray the cost of uncompensated care — would be converted into grants to states for health insurance coverage, health promotion and disease prevention. The program would target assistance to individuals who are not eligible for Medicaid, who have incomes less than 150 percent of poverty, and whose unreimbursed payments for health insurance premiums and medical care, net of federal tax credits, exceed 5 percent of their adjusted gross income.

Consumer Protections

- The Federal government will continue to police insurance programs to protect consumers from being defrauded. Federal criminal penalties are established against health care providers and insurers who knowingly defraud persons in connection with a health care transaction.

Anti-Trust Provisions

- The bill will create "safe harbors" from federal anti-trust laws for: certain groups of providers; medical self-regulatory entities that do not operate for financial gain; certain joint ventures for high technology and costly equipment and services; and certain hospital mergers. It directs the Attorney General to create additional "safe harbors" for health care joint ventures that would increase access to health care, enhance health care quality, establish cost efficiencies from which consumers would benefit, and otherwise make health care services more effective, affordable and efficient.

- The Attorney General also is required to establish a program through which certain providers may obtain certificates exempting from anti-trust laws activities relating to the provision of health care services.

Long-Term Care

- Amounts withdrawn from individual retirement accounts (IRAs) and 401(k) plans for long-term care insurance are excluded from income. The bill also provides that certain exchanges of life insurance policies for long-term care insurance policies are not taxable. It also exempts from taxation any amount paid or advanced from a life insurance contract to a terminally or chronically ill individual who is confined to a hospice or nursing home.



News from

Congressman JIM RAMSTAD

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**STATEMENT OF CONGRESSMAN JIM RAMSTAD
BEFORE THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
THE CONSUMER CHOICE AND HEALTH SECURITY ACT
February 9, 1994**

Mr. Chairman, thank you for giving us the opportunity to discuss our bill, the Consumer Choice and Health Security Act, this morning. I've enjoyed working with you on legislation to eliminate the work disincentives facing disabled Americans who receive SSI payments and I hope we can work together on health care reform legislation as well.

Few dispute the need for health care reform. Our families are seeing their health costs rise at nearly twice the rate of inflation. Every year millions of Americans go without coverage.

We have correctly diagnosed the disease. Now it is time for strong medicine.

Our package will give all Americans the same choice that the nation's public servants currently have. This legislation would allow every family to choose from among dozens of health plans competing on the basis of cost and quality.

Furthermore, the federal employees health benefits plan on which this proposal is modeled has consistently outperformed other private and public sector health insurance programs in holding down its rate increases.

Mr. Chairman, this is truly a reform package on which Republicans and Democrats can agree. It provides universal coverage while preserving America's high quality health care delivery system -- the best in the world.

Like many Americans, I am dubious of President Clinton's health care plan.

The Clinton's "one-size fits none" benefits package turns administration of our entire health care delivery system over to thousands of new state and federal government bureaucrats.

Instead of expanding the authority of government, we need health care reform that preserves the high quality of care Americans have come to expect and eliminates the perverse incentives that are driving the health price spiral.

Our plan would eliminate unfair insurance practices such as pre-existing exclusion clauses and guarantee our workers that when they change jobs, their health insurance will go with them.

And most importantly, what we promise in this bill we can pay for. According to Lewin-VHI, one of the nation's most respected economic forecasting firms, this package is budget neutral.

This pro-family, pro-individual package is truly the cure for our health care system ills.

Thanks again for this opportunity. I look forward to working with you on this important issue.

Chairman STARK. At this point, I yield to my good friend, Rod Grams. Who I suppose won't complain about his health care either.

STATEMENT OF HON. ROD GRAMS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. GRAMS. No, I don't.

Chairman STARK. All right. Good to see you. I welcome you to the committee.

Mr. GRAMS. Thank you very much. I thank the chairman and the committee members for the invitation to appear before them this morning, and I am pleased to join with Congressman Cliff Stearns and Senator Nickles in full support of H.R. 3698 which is the Consumer Choice Health Security Act.

Now, after hours of listening to my constituents in Minnesota and their suggestions on health care, I believe Congress must pass some comprehensive reform legislation which will, first, make health care affordable for all Americans, regardless of income, second, ensure universal coverage and prohibit discrimination against preexisting medical conditions, third, guarantee insurance portability, fourth, enhance consumer choice, and fifth, treat Members of Congress just like all other Americans.

These are many of the same principles that the President himself enunciated in the State of the Union Address. Let me read to you a few excerpts from the President's speech that night.

"Now, in the coming months, I hope very much to work with both Democrats and Republicans," the President said, "to reform a health care system by using the market to bring down costs and to achieve a lasting health security." He went on to say, "The American people provide those of us in Government service with terrific health care benefits at reasonable costs. We have health care that is always there. I think we need to give every hard-working, tax-paying American the same health security that they have already given us." Finally, he said, "If you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen, veto the legislation, and we will come right back here and start all over again."

Well, when I sat there that night in the House chamber, I thought to myself that the President was basically endorsing the Nickles-Stearns plan. Of all health care proposals now in Congress, only the Nickles-Stearns plan is using market forces to reduce health care costs, guarantees universal affordable private health insurance, increases the number of health insurance plans available to the average American, and ensures insurance portability and nondiscrimination against preexisting conditions.

The Nickles-Stearns plan is also modeled after, again as Congressman Stearns enunciated, the Federal employee health benefits program which has provided health insurance to Members of Congress and Federal employees for 33 years at an average cost of one-third less than other private health insurance plans.

Unlike most plans, including the President's, the Consumer Choice Health Security Act accomplishes all of this without undue Government interference. As my hometown newspaper, the Minneapolis Star Tribune, reports, "The Nickles-Stearns bill tells Gov-

ernment to give consumers the dollars and lots of choices and then get out of the way."

Reforming health care with as little Government interference as possible is a message that I hear every day from average Minnesota citizens, and who can blame them. How can the average American put his or her trust in a Congress which can't run its own bank or post office to administer a \$900 billion industry like health care? Decisions about health care should be left to individual consumers and their families, not to national health boards or alliances, and that is what the Nickles-Stearns bill does.

One of the key roles this bill transfers from Government to consumers is deciding where to purchase their health insurance. The current Tax Code penalizes those who cannot or choose not to receive their coverage through their employer. This list includes farmers, self-employed individuals, the temporarily unemployed, people changing jobs, and those suffering from illnesses or injuries not covered by their employer's one-size-fits-all insurance plan.

By replacing the current exclusion for employer-based insurance with individual tax credits, the Nickles-Stearns plan gives consumers an opportunity to shop around for a health plan that best suits their needs. It does not eliminate employer-based insurance, but the bill simply offers consumers more choices and introduces greater competition in the insurance market, thereby resulting in lower costs.

Now moving the emphasis away from employer-based health insurance, we will also eliminate the problem of job lock. By loosening the tie between a job and health insurance, no longer will people be forced to decide between taking a new job or losing their medical coverage. The Nickles-Stearns plan guarantees health care that is always there, regardless of whether you work for employer ABC, employer YZ, or no employer at all. All insurance reforms in this bill will ensure that no one will be denied insurance because of any preexisting medical condition.

Finally, since the individual tax credits are determined on a sliding scale based on income and cost of health care expenditures, the Nickles-Stearns bill will help low- and moderate-income Americans the most. It is a progressive plan which ensures that those who truly need the most assistance to purchase health insurance will have access to it.

Health care costs, universal coverage, insurance portability, and consumer choice, these are the problems that we as a Congress must address in this year's health care debate, and we must do it without creating a new government-run program which would result in a real health care crisis. The answer, my colleagues, is the Consumer Choice Health Security Act, and I strongly urge you to do what is right for the Nation and help pass this legislation.

Thank you.

Chairman STARK. Thank you.

Now we will hear from another distinguished member of our subcommittee and full committee, Mr. McCrery.

STATEMENT OF HON. JIM MCCRERY, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF LOUISIANA

Mr. McCrery. Thank you, Mr. Chairman, and I appreciate your allowing me the opportunity to testify today in spite of the fact I do not have a bill yet introduced.

I am currently working with the legislative counsel to refine the document, and I hope to soon have that introduced. The title of the bill will be the Health Savings and Security Act of 1994, and it has many similarities to the bills that you have heard described this morning. It has an antitrust reform for providers, rural health care incentives, medical malpractice reform, insurance reform such as doing away with preexisting conditions, guaranteed renewability, limitations on premium increases for people who get sick, narrowing the bands of underwriting, and increased portability.

We also provide tax deductibility for the self-employed and for individuals whose employers do not provide them insurance. We also provide refundable tax credits for low-income individuals who purchase insurance and tax credits for individuals who purchase preventive health care.

As we go through the debate in Congress, the thing that I hope we concentrate on most is the escalating health care cost in our health care system. That, to me, creates many of the other problems that we talk about. I believe that of the options out there, certainly, Mr. McDermott's option and your option, a single-payer option is a legitimate way to address the problem of rising health care cost. However, like some medicines, that solution has some side effects, and I am not yet ready to sign on to those side effects.

When one begins to think about how to cure a problem, he ought to try to investigate the causes, and while there are many, many causes for escalating health care cost, it is my opinion, after much reading and research, that the primary problem in our system is the lack of incentives for individuals in our society to control cost.

The third-party payment system in the health care system in the United States is pervasive. It controls the system, and it saps any responsibility, any individual responsibility from our system.

My plan, I think more than any others presented this morning, addresses that problem. We do that in addition to all the reforms that I have already mentioned. We do that by encouraging through the tax system the purchase of high-deductible policies of insurance, coupled with medical savings accounts, allowing individuals to spend cash for basic health care and preventive health care, and, of course, you are familiar with the concept anything they don't spend out of their medical savings account, they are allowed to keep in that account, rolling it over, year to year, accumulating what they can in their medical savings account, and at some age, say 65, they can convert that to an IRA and use that for anything they like if they pay taxes on it when they withdraw it.

They could also under my plan use their medical savings account proceeds to purchase long-term care insurance, and that would be tax-free, as would any other expenditures for health care.

I would also allow a tax deduction for the purchase of a managed care option. I also encourage the creation of small employer-purchasing pools for small employers as well as individuals.

That, Mr. Chairman, summarizes my plan. I appreciate very much your allowing me to testify today, and I hope you will allow me to include in the record a brief summary, a 1-page, front-and-back summary, of my plan.

[The prepared statement follows:]

Health Savings and Security Act of 1994 by Representative Jim McCrery

Insurance Reforms

Guaranteed Issue and Renewal.

No denial of coverage for pre-existing condition.

Premium differentials only for age, geography and gender.

Creates voluntary insurance pooling reforms for small businesses and individuals to provide lower premiums through group coverage.

Tax Changes

Provide Capped Employer Tax Deduction and Employee Tax Exclusion for Health Insurance Policy *(The deduction and exclusion are limited to policies valued no more than \$2,500 per adult up to \$5,000 total and \$500 per dependent up to \$1,500 total, with geographic cost of living adjustment).* Employer tax deduction allowed only for an employer provided Medical Savings Account/ High Deductible Umbrella Insurance Plan (minimum \$1,500 and maximum \$3,000 deductible) **OR** a managed care (HMO) plan.

Provide Individuals 31 Percent Tax Credit. Tax credit is provided only for Medical Savings Account/High Deductible Insurance Plan or managed care plan. Equalizes treatment for self-employed and individuals without employer offered qualified health insurance.

Refundable Tax Credit for Low Income Persons for Purchase of a High Deductible Umbrella Insurance Policy or Managed Care Plan.

65 percent credit for up to 110% of poverty.

60 percent credit for 110% to 120% of poverty.

55 percent credit for 120% to 130% of poverty.

50 percent credit for 130% to 140% of poverty.

40 percent credit for 140% to 150% of poverty.

40 to 31 percent phase out credit for 150% to 160% of poverty.

Tax Credits for Non-MSA Preventive Care. 31% tax credit for routine preventive care for those without a Medical Savings Account or qualifying managed care plan.

Tax Incentives for Practice in Rural and Urban Underserved Areas. Physicians practicing in rural, frontier, or underserved urban areas are allowed a tax credit equal to \$1,000 a month. Nurse practitioners and physician assistants would also be eligible for a similar credit up to \$500 per month. Includes mandatory service period with recapture if service is less than 5 years.

Health Savings and Security Act of 1994 by Representative Jim McCrery

Medicaid Reforms

Increase State Flexibility in Medicaid for Acute Care. At state option, the Medicaid program will permit AFDC and SSI recipients to receive medical assistance through enrollment in managed care or MSA/high deductible umbrella offered in regional voluntary insurance pools.

Provide Federal Budget Savings by Limiting Acute Care Medicaid Payments. Eliminate disproportionate share payments. 20 percent increase in 1996 over 1994.
1997=CPI+3%; 1998=CPI+2%; 1999=CPI+1%; 2000 and thereafter=CPI.

Tort Reform

Provides states with a set of uniform standards for resolving medical malpractice disputes.

Promotes pretrial alternative dispute resolution to encourage reasonable settlements.

Eliminates joint and several liability for non-economic damages.

Limits non-economic damages to \$250,000.

Includes medical products and devices in health care liability actions.

Anti-Trust Changes

Facilitates the sharing of expensive, underutilized medical equipment by health care providers, and creates a more flexible anti-trust policy environment for the evolving health care market.

Statutory Safe Harbors

The "Safe harbors" apply to: (1) small provider combinations; (2) activities of medical self-regulatory entities; (3) participation in certain surveys of cost, price, reimbursement, and employee wages & benefits; (4) joint ventures for high technology, other costly equipment & services; (5) small hospital mergers; (6) joint purchasing arrangements; & (7) good faith negotiations.

Certificates of Review (Waivers) Awarded by the Attorney General

Providers may petition the Attorney General for certificates of review to obtain antitrust exemption. If the AG does not reject the application within 90 days, the activity is deemed approved.

Joint Venture Notifications for Reduction of Antitrust Penalties

Upon notification and publication of members in a joint venture, health care providers can limit potential antitrust penalties that may be imposed against the venture.

Underserved Areas

Several new programs are authorized to provide medical services in underserved rural and urban areas.

Chairman STARK. Without objection.

Mr. MCCRERY. Thank you.

Chairman STARK. I have a couple of comments. I am relieved, with the exception of Mr. Payne, to find that the minority party has as much trouble getting an agreement among itself as the majority party. So welcome to the consternation and confusion club, as we try and find a package that will answer the President's challenge of universal coverage and get 218 votes in the House.

I wanted to ask Rod this. You said something about the government's inability, and I would stipulate as to our problems with the bank, but I presume that you have no problem with the way Government runs Medicare and would not want to be by yourself in voting to eliminate Medicare.

Mr. GRAMS. Medicare would stay as it is, but I think there could be some reforms in their handling of Medicare, of course.

Chairman STARK. Some improvement, but we like to think on this committee that it stands as a symbol of what bureaucracy can do, and we are always a little touchy about that.

Mr. GRAMS. I understand.

Chairman STARK. We think we do a better job than the House Bank, all right?

Mr. GRAMS. But when I talk to most constituents, none of them really believe that the Government can better handle health care than individuals of the private sector, and this is what I get back so many times from individuals. In fact, at most town hall meetings, they have one phrase for me, and that is "keep Government out of my health care."

Chairman STARK. But they don't say that about Medicare because, if we closed up Medicare, they wouldn't have any insurance. It is interesting. My constituents say the same thing, "Oh, Medicare is different," and that is a conundrum we will have to deal with.

I have a couple of questions on the Grandy-Cooper bill. Is that right?

Mr. GRANDY. Cooper-Grandy bill, Mr. Chairman.

Chairman STARK. Cooper-Grandy. All right.

Mr. GRANDY. We are on the other side of the Mississippi.

Chairman STARK. You repeal Medicaid and, in so doing, do away with the only source of public support for long-term nursing home care. It eliminates the nursing home reform amendments that we put in, in 1987, and Mr. Cooper did suggest that he had a long-term care provision that he was going to add back and reintroduce. Is that still in the works?

Mr. GRANDY. That is in the works, Mr. Chairman. We federalized the acute care portion of Medicaid. It is not a repeal of Title I. We had this discussion with Chairman Waxman in front of the Energy and Commerce Committee.

The long-term care provision is structured in such a way, so that there is a 4-year phasein of subsidies to those States that would be getting, obviously, State control of their long-term care dollars, but might be losing money under the acute care federalization. So, in other words, the States that would be in the short run disadvantaged would have a subsidy to provide them with the dollars they would lose.

Chairman STARK. But the States don't have to maintain any effort or any payment for the Medicaid cost they now have or do you require maintenance of effort by the States?

Mr. PAYNE. There is a requirement of maintenance of effort on long-term care. States like my own, Virginia, which spends 57 percent of its dollars on acute care and 43 percent on long-term care, would actually have more dollars to spend on long-term care as a result of this proposal.

Chairman STARK. I am going to take exception to your bureaucracy statement because I think you create one, and hear me out on this. Health plans and the HPPCs would be forced to absorb a loss from enrolling a disproportionate number of low-income individuals with vouchers. To compensate those plans, you have created a reconciliation process which would be coordinated by the National Commission. It would attempt to equalize the payments within HPPC plans across the country and across self-insured plans which aren't in the HPPC.

So my postulate is that essentially require this National Commission to tax all health plans, including self-insured plans, in order to compensate those plans that enroll a disproportionate share of low-income, vouchered individuals. Is that not correct?

Mr. GRANDY. My understanding, Mr. Chairman, is that we have a fall-back mechanism to provide full funding for low-income individuals if the Federal funding falls short.

Chairman STARK. Right. So you tax all the plans, and the National Commission makes the adjustment to compensate. The plans would get hit. It is sort of a risk adjustment, but it is an equalization process. The President does somewhat the same thing.

Mr. GRANDY. This would only happen, Mr. Chairman, if Congress did not raise the sufficient funds. In other words, it is a fall-back mechanism.

Chairman STARK. Yes. All right. That is what the President has, the same thing, but it needs then to tax the plans or raise the money from the plans to redistribute within the HPPCs and the self-insured plans.

Mr. GRANDY. That would be the consequence of Congress didn't do its job, yes.

Chairman STARK. OK. I have just suggested that would take some bureaucracy.

Now, if a firm has over 100 employees and an employee in that firm gets cancer, is there any limit on how much an insurance company insuring that firm could increase the employee's premium, and is there anything that would prohibit the insurance companies from cancelling that coverage?

Mr. PAYNE. If you would wait just 1 minute and let us consult.

Chairman STARK. I don't think there is. You can offer amendments to correct this. I point this out, L.F., not in a manner of hostility, but these are all the same problems that have been leveled at many plans.

I only say it to suggest that, in my opinion, creating HPPCs, even though they may rely on competition, can create the same problems in the absence of this sort of absolute purity which none of us can write in. There is no perfect competition.

I am not sure that we are going to be able to write, absent single payers, as my distinguished colleague will suggest, a plan that doesn't create some of these disconnects.

Mr. GRANDY. Mr. Chairman, as I think you just implied, there are assumptions in all of these plans, single payer included.

Chairman STARK. Right.

Mr. GRANDY. The assumption that we make with the 100-employee threshold is that above that number, an illness such as cancer, a catastrophic payout would not necessarily drive up the premium so disproportionately above that number that you would see a precipitous increase.

Chairman STARK. But there are companies, like Golden Rule who have a long history and 1,000 lawsuits against them, where they do just that. We don't have any control. There is always the bad apple that spoils the barrel, and I have felt for a long time that we have to prohibit that by creating an open enrollment or not allowing medical underwriting, which you do under 100 and obviously could correct this just by taking that 100 cap off.

My time has expired.

Mr. THOMAS. Mr. Chairman, that is exactly why in examining the options we believe that purchasing cooperatives have a lot of potential, but they are imperfect currently. Therefore, they should be allowed. We should structure it. We should change antitrust provisions. We should reform the insurance market, but we should let the market competition continue to define this rather than have us sit down and try to devise a perfect world. There is on perfect world, and we have purchasing cooperatives, but they are nonmandatory.

Chairman STARK. Dr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman. I want to commend you for having this hearing.

I think this is one of the better hearings we have had because, actually, members are sitting, talking to members and getting an opportunity to at least hear how the other person thinks about this issue. I think in this debate, that is going to put us a lot further down the road.

I would suggest that preconceptions people have about plans really need to be held in abeyance a little bit. Over in the Education and Labor Committee, the American College of Surgeons just endorsed the single-payer plan. So I think the game is still on the field, and I think this kind of discussion is very important.

I would like to hear some thinking. Unfortunately, I have got questions for everybody because I found myself agreeing with some of what each of you said, but I am going to focus on L.F. and Mr. Grandy for a second because yours is the plan that probably goes the furthest in terms of answering the question that everybody gets hung up on, and that is the question of where do you get the money for this.

The tax cap that is in your bill, as I understand it, operates in that the company that provides health insurance for their employee can deduct only that amount equal to the lowest-cost plan in the area. They lose the deductibility for anything they purchase for their employees beyond that, and if they do purchase for their

employees, they pay a 34-percent excise tax on the benefits they provide.

To me, that is a tremendous financial lever; the employer then has to say to his employees, "We are getting out of the benefit package business. We will pay for your low-cost benefit, and you can go out and buy whatever you want," and I understand that may be what you wanted to create.

What is hard for me to understand is what you think the impact will be across this country in terms of taking away the tax deductibility of health insurance that, as Mr. Stearns suggests, has been built up since the second World War. Workers have foregone wages in order to get a benefit package in negotiations all across this country.

Boeing employees have stood in the rain three times in a row over their benefit package on strikes. We are not talking about a minor issue here.

I would like to hear your thinking about what the impact is going to be on society if you take away the deductibility of everybody's health care insurance except for the lowest-cost plan in the area.

Mr. GRANDY. Dr. McDermott, let me try a stab at this. This was brought up at Energy and Commerce as well, and you were a little kinder than your colleagues over there. You didn't actually accuse us of raising taxes on the middle class, but somewhere lurking in your statement is that inference.

Mr. GRANDY. I put it in the press release.

Mr. MCDERMOTT. I didn't want to bring it here because I really would like to understand your thinking.

Mr. GRANDY. Let me say, first of all, one of the statements that I think stuck in my mind when we began this debate and one of the ones that I think drives the thinking behind the Cooper-Grandy bill is something that Dr. Everett Koop said when he came up and appeared with the First Lady when he said that there is a problem in this country, not solely that there are too many Americans with too little health insurance, but there are probably a significant number of Americans who have too much.

Right now employer-provided benefits and that deductibility is the third-largest health care entitlement the Federal Government bestows, and that has created, I think, a surfeit of benefits and perhaps a wedge in the labor-management relationship to basically concentrate more on benefits which are not taxable than wages which are.

The purpose behind our attempt to limit the deductibility, but not the exclusivity to the individual, is to allow some of that redistribution to go to those people that don't have any health care or too little. If my colleague, Mr. Cooper, were here, he would describe this as trying to take away the Cadillac right to everyone, so that everybody could have a Chevy.

Basically, the threat there, as you point out, is that employers perhaps will start to shorten up on their benefits. If that were to happen, and I am not necessarily sure that is a consequence of this action, but if it were, the individual, because exclusivity remains, can go out, buy extra benefits if they so choose, and deduct that because 100-percent exclusivity still remains in play. If they are

low-income individuals, there will be subsidies to that effect to provide them if they feel as though their benefits are too small.

What we are reducing, though, and we are admitting this and are proud to admit this, is that we are trying to shorten up on what we think has been an enormous corporate subsidy under the guise of health care benefits over the last few years, a subsidy that perhaps has run away. Contrary to the Clinton plan which continues that subsidy for 10 years, a kind of period, a grace period, for which all Americans will play, including low-income individuals, we are trying to stop that now.

So, if that is a tax increase to you, I would say that is a middle-income tax cut to those of us that believe this because the individual, the person without the benefit, the person with too little insurance, I think is going to wind up getting a benefit, a more generous benefit, or perhaps one that they don't have at all in return for perhaps large corporations, whether it is Boeing or Chrysler or American Airlines, perhaps, if you are right, downsizing their benefits.

I guess I would say, finally, I am not sure that they all will because I think that health care is a significant bargaining chip in any labor negotiation, and I am not sure that you would necessarily see all of the employers of America disinvesting in health care right away.

Mr. GRANDY. I agree with you, and I would predict great labor unrest. Every major labor dispute in this country in the last 5 years, perhaps longer, has been related to the benefit package.

Mr. McDERMOTT. But that is not necessarily good, I don't think. I mean, what you have seen on the other side is that wages have shortened up. Wages have remained stagnant in this country, and benefits have exploded. One is taxable; the other isn't.

Mr. GRANDY. My belief is that you increase the pressure, management is going to say, "If we give you this benefit package, we are going to have to pay a 34-percent excise tax on what we pay you above the very minimum package in our neighborhood," and from my standpoint, the stockholders are going to be saying to the management, "You've got to offload this cost onto the employees." I mean, that is what we have been doing. We have been watching since about 1980. The number of people insured in this country has been dropping because employers have been trying. First, they got rid of the children and then they got rid of the spouse, and so now they are trying to get only the employee that they are covering because they have tried to offload parts of the health care cost.

This, to me, is a tremendous lever that the stockholders are going to use on the management and say, "If you want your job, get rid of some of these costs. Get rid of the health care cost. Put it on the employees."

Let me make one more point, and then I will yield to Mrs. Johnson. I don't want to leave the impression with this committee, and we did not leave it with Energy and Commerce, that this low-cost health care plan, as it was described in Energy and Commerce, is somehow some cut-rate de minimis plan that nobody can really use. We may not be as comprehensive as the administration's plan, but we are not talking about some kind of cheap subset of health care benefits that a lot of people have now.

Will in vitro fertilization be in it? Probably not, but most of the care that a lot of people, I think, would expect under a basic plan will be, and if the consequence of all of this is that managers and CEOs find themselves having to take what they used to pay in benefits and transferring over to wages, I think labor is advantaged.

I will yield to Mrs. Johnson.

Mr. McDERMOTT. May I just make one clarification before Mrs. Johnson?

Mr. GRANDY. Yes.

Mr. McDERMOTT. I would feel much better about this proposal if you had written your benefit package into the law, so I know what it is, instead of giving it to a board who is going to define it after we have passed the bill and left town.

I did one of those in the State of Washington, and they left mental health benefits out of a bill I wrote. So I don't trust commissions. That is why I am a little wary of your low-cost plan, what that will amount to.

Mr. GRANDY. Mr. Cooper has said in front of Energy and Commerce that in the interim while we are waiting for the standard commission to be created and empowered, there might be an opportunity to create an interim set of benefits. Could we count on your support if we were able to do that? I mean, could we sign you up as a cosponsor at that point?

Mr. McDERMOTT. Let me see the benefit package.

Mrs. JOHNSON. Mr. McDermott, two comments. First of all, I think you can write generic descriptions of a basic benefit package that would address the problem that you had with your Washington situation, but I am very nervous, and I think this committee ought to be particularly conscious of the down side of a specific benefit package because we have seen ourselves write tax law that had a catastrophic impact on a certain set of businesses that we simply never thought about.

Congress has literally put people out of business because it is unable to change the law in a timely fashion to save people who legitimately should have been saved.

As a woman, I do not want a Federal law that says how often I can have a mammogram because I know if it says it today and the science decides tomorrow I should have it more often, it will be very hard for us to change that law, just like it took us, what, 3 or 4 years to get any reimbursement at all for mammograms for women. So what we heard in our hearing yesterday was that government doesn't have a flexible-enough process to either respond, to benefit changes driven by science, or to plan ahead.

Those long waits that we heard extensive discussion of yesterday were directly the response of Canada not being able to see in the 1980s the disease patterns of the 1990s and, therefore, put in place the resources. So I think there are some issues about benefit plan specificity in Federal law that we really have to address.

To the earlier issue that you raised about tax deductibility, there is an issue of equity that health care reform has to address, and we really have only two choices. Do we address it through a consistent policy of defining what government will subsidize and what it won't or do we not address it at all? I would maintain that the

President's proposal, for instance, for premiums that will automatically step down won't address it.

Right now we have people who pay a large amount of money for a very poor package, effectively subsidizing through their income taxes those first-dollar coverage, Cadillac plans that you are referring to because they are all subsidized through tax expenditures. It seems to me only fair and reasonable to pull back our subsidy of those plans to the benefit plan that everybody has access to. That is a matter of equity, and I think health care policy has got to be equitable if we don't do that, and the President doesn't, and since the President doesn't, we have this phenomena. We have pressure on premiums so that they will go downward. That will make less money available for service reimbursement, but those big plans will still have every incentive to overuse and no block on the drain on money to pay for that overuse, further depleting available funds for those within the system who have a less generous plan than the first-dollar coverage people.

So the equity issues that lie behind your question are very serious, and while I personally as a cosponsor of the Cooper-Grandy bill am troubled by tying deductibility to the lowest-cost plan, I think there is a point at which we can say this is what society is willing to subsidize, and we are going to do it for seniors, we are going to do it for middle-class working people, we are going to do it for Medicaid people, and we are not going to do more than that, but equity has got to be addressed as we move through health care reform.

Mr. McDERMOTT. I agree with you on the equity question, and that is why, frankly, single payer makes more sense to me because it is a big issue, and I understand now why you are thinking what you are thinking, but is it your belief that the people who are getting Medicare will be brought down to some low-cost plan or will that always sit out there as a plan unaffected by the rest of what is going on in this process?

Mrs. JOHNSON. Frankly, Medicare is not so great, and there are a lot of things that aren't available to you under Medicare.

Furthermore, for some people, the copayments are very steep. So I think, yes, we are trying to establish a health care plan in which we are going to subsidize costs for low-income people, and that should be consistent. Gradually, we should move toward a benefit package that is consistent, and we are recognizing that in Congress. We are just doing it through the backdoor, but when we change the premium rates for upper-income seniors, we are doing subtly the same kind of things.

So I think we need to work toward absolutely consistent policy, and age should not be a factor. Quality care, affordable care, taking into account resources in society as well as individual resources, are those things that ultimately should guide us. While we may not get there entirely on the first round of health care policy reform this session over the long haul, absolutely I am looking for equity, and most of the seniors I represent would be perfectly happy to know that they got exactly the same support and help according to income and quality plans that everyone else is getting.

Mr. THOMAS. Mr. Chairman.

Mr. McCRERY. Mr. Chairman, I want to add to the discussion on this for just a moment.

Mr. THOMAS. As do I.

Chairman STARK. All right.

Mr. McCRERY. I will defer to my senior colleague on the committee.

Mr. THOMAS. Although no questions have been directed to the package, it obviously contains somewhat similar concept, and I want to make sure that in the discussion of a tax cap on fringe benefits, although the Cooper-Grandy plan has it at the lowest-cost plan available in an area and in the Chafee-Thomas, it is the average of the lower half, I believe that flexibility does allow you to make some judgments that are not available in the other structure, but I want to talk to the larger question.

Over the last 20 years, compensation has gone up 12 percent. Wages have gone down 6 percent. To reinforce the point that Mr. Grandy has made, there has been under the rules that we currently have a drive toward fringe benefits. It is not a right. It is not a responsibility. It is a rule under which we established a way in which collective bargaining and other negotiations outside the collective bargaining structure could be carried out between management and employees.

If you are telling me now that unions are going to come unglued, what I think you need to do is realize that you can't have your argument both ways. They achieve the fringe benefits under the rules through collective bargaining. None of these bills repeal collective bargaining.

If the pressure on the employer is that we have got to bail out of the fringe benefits because they are not a freebie anymore, we have changed the rules, as we should have a decade ago. Then what you are going to get is pressure on the hand of the labor union to increase wages. If you are going to take away what we already negotiated because the rules have changed, then put it back on the wage side in those collective bargaining structures.

So I don't think the unions have anything to fear. I think those folks who might be under a nonunion structure in which the employer has a greater right to deal with it would, in fact, be concerned.

Now, what do you do with the money from the cap on the fringe benefit? Take a look at the Chafee-Thomas bill. We anticipated the concern that you have not so much for the collective bargaining people. They are going to be able to take care of themselves under the current structure, but for those folk who may wind up having to insure themselves now because the employer pulls away from it, we take the money scored by the Joint Tax Committee with that tax cap, and we use the low Blue Cross/Blue Shield as our model, which is not a skinnied-down package, as Mr. Grandy indicated, it is a relatively decent package.

The money that you save with that tax cap gives 100-percent deductibility for the self-employed. Now, how about equity there? I think you need the equity for the self-employed. We pay for it. Then all of those who are currently not being paid for by the employer on their insurance, up to the tax cap, would be covered as well by that money.

So, one, it creates a discipline that should have been there 10 years ago. Two, it provides a funding source that offsets those who are now insuring themselves up to that nice package and 100-percent deductibility for self-employed, and it provides over \$7 billion to initiate the voucher structure along with the Medicare savings to make sure that those people, up to 90 percent of the poverty level, initially, working up to 240 percent of the poverty level, through the existing Treasury collection and dissemination structure, begin to get help in buying that insurance that they cannot now afford.

I think if you look at it that way, you will see that an individual mandate tied to the tax cap does have a synergism that works well in making fundamental changes in the marketplace, if you change the insurance incentives, if you change antitrust reform to allow for small business, among others, to capitalize on the changes that you are putting in the system.

Mr. McDERMOTT. I would agree with you that the people most at risk are the nonorganized or the unorganized; that the organized people make up 19 percent of the work force. So they are really not the main issue. It is really the unorganized where the employer will have all of the leverage, and the employees will be totally unprotected in that struggle, at least by my view.

Mr. THOMAS. I understand that, but your point was that the labor unions will come unglued. Now they are only 19 percent of the marketplace.

Mr. McDERMOTT. No, no, no.

Mr. THOMAS. Once again, you can't have it both ways. Either these people have got a good deal and they are going to collect it in wages or they are not strong enough to drive the decisionmaking unless you are a member of the Democratic party and they are inside your group making sure that a good change like this won't be part of a compromise.

Mr. McDERMOTT. I was just suggesting that they would go on strike. They can do that, and if you want labor strikes and labor unrest in this country, then you establish a social policy that pits two people against each other, and you can make social policy. Now, that was my question. I am not saying you intend that.

Mr. THOMAS. First of all, before I got into this job, I negotiated fringe benefits—

Mr. McDERMOTT. I know that.

Mr. THOMAS [continuing]. Under the rules, and what we did was sit around and dream up ways to go after that money beyond a decent normal package.

You know what they came up with? We came up with an 8-percent tax-sheltered annuity funded through fringe benefits. What I did when I came up here was knock out any dollar benefit from any kind of a fringe benefit package where you could collect money at the end of the year because I thought that was wrong. At the time, those were the rules. We partially changed the rules in that regard.

What you are going to find out there is not this enormous action to go on strike. What you are going to find is, hey, guys, the game is up. We were able to play it for longer than we should have, and now we are going to have to redefine the way in which we relate

with each other, and wouldn't it be wonderful if the solution between management and labor is that we are going to give you a wage and you are going to decide for yourself how to pay for it instead of pumping it into that tax-free fringe benefit area in which third-party players have distorted the system for too long.

Mr. McCRERY. Mr. Chairman, if I might just add a quick note here.

Chairman STARK. Go ahead.

Mr. McCRERY. I think this is an appropriate discussion for this tax-writing committee because what we are talking about, really, is tax expenditures. When you talk about deduction, you are talking about tax expenditures. It is really like a spending program.

Mr. THOMAS. Would the gentleman yield briefly?

Chairman STARK. If we could have one witness at a time.

Mr. THOMAS. Could I have my 5 minutes, so the light would be green?

Chairman STARK. You have had more than your 5 minutes.

Mr. McCrery.

Mr. McCRERY. Thank you, Mr. Chairman.

I agree, I think, with you, Mr. McDermott, as you are an advocate of a single-payer system, that we ought to use the tax system in whatever manner to offer incentives for insurance or for health care to the broadest possible array of citizens in this country, and that is what a tax cap is all about. So it is a little surprising to me that a criticism of that attempt by some of us, a few of us on the Republican side, I might say, to broaden the base of people who benefit from these tax expenditures would come from a single-payer advocate, which takes that thought to the extreme of giving everybody the same benefits for the tax expenditures that we make. So I am surprised that you would make that negative comment about an attempt by some of us to further liberalize the tax expenditures.

Mr. McDERMOTT. Let me just suggest one of the quibbles I have and the reason I raise it is I guarantee universal coverage.

Mr. McCRERY. And we are trying to guarantee it to more people.

Mr. McDERMOTT. You can't guarantee it to more people than everybody.

Mr. McCRERY. Sure, we can.

Mr. McDERMOTT. I have got everybody.

Mr. McCRERY. If we spread the tax deduction around to more people, Mr. McDermott, we allow more people to get in.

Chairman STARK. Only in Cook County, and we don't talk about that.

I have one comment, and I would take part in this. This is only relevant to future witnesses, as we have heard some discussion, and we will, about individuals choosing. It becomes very important to empower the individual.

It has always been a feeling of mine that among us—we had 7 at the witness stand and a couple of here—without the help of our staffs and with nothing written on your shirt cuffs, I am going to speculate that we are arguably far more knowledgeable about health insurance benefits than the average person in the country, not a provider, but the average man on the street, we here on the

dais and the witness panel, I don't think you can get a much more well-informed group.

I am further going to suggest that there isn't a one of us that could score a 70 percent passing grade on my test to describe in any detail what our health benefits are. Deductibles, out-of-pocket, copay on the hospital, copay on the docks, preventive care, mental health benefits, prescription drug benefit, dental benefit, home health care, durable medical equipment, I am not sure I could tell you. I could run back to my office and get my policy, but I am not sure. I just say that to say that I am not sure it is reasonable to expect the average person on the street who hasn't had our experience of having to grind through this, with as much knowledge as they could have, and we have had more knowledge than many of us may want to have.

I only say that when you think through this idea of completely empowering an individual. It may speak to the need for purchasing groups. It may speak to the need for bargain plans. If anybody wants to challenge me on them, I will give you the test, but I don't think we can do that because we don't anticipate being sick, unless you have just had a member of your family who has needed to use the insurance, you haven't looked at the policy, and maybe once a year we read through the book when we select for the Federal Employees Benefit Plan. Even then, we may look at it just to renew what we have.

I hope you will keep that in mind as we begin to just throw everything on our constituents. They will be able to use some help, and I am not so sure that defining some benefit plans, some of those things are a bad idea.

Mr. STEARNS. Will the chairman—

Chairman STARK. Do you want to take the test?

Mr. STEARNS. I don't want to take the test, but I would also be glad to take the test with my independent insurance agent by my side, and I think almost every American has an independent insurance agent when they buy their automobile insurance, they buy their life insurance, and when they buy a multitude of things, like even mortgages.

Chairman STARK. You have just established one cost parameter. You want to pay an extra 15 percent to accomplish to provide the answer to the question I just asked to the total health insurance cost to this country. I think we can find a less-expensive way.

Mr. STEARNS. I would just advocate that in the free market, that 15 percent would be made up in lower cost if the individual made the decisions with the help rather than the Congress or a national board set up or something, as Mr. McDermott says, after we adjourn Congress. So, I mean, my argument again is for individual choice.

Chairman STARK. I would buy that. If it weren't the same insurance salesman that sold my mother that Prudential real estate investment, I would probably go along with you.

Mr. STEARNS. All Americans buy automobile insurance, and the main are successful.

Chairman STARK. All right. Class, if you would like to resume the seats you had before, this session of our class started, we will get on with it.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. PAYNE. Mr. Chairman, may I say one thing as we conclude? Chairman STARK. Please.

Mr. PAYNE. I am of a different persuasion than the rest of my fellow witnesses here. The reason that I am here with Brad and a part of this Cooper bill is that I do feel very strongly that, as we conclude health care reform, we have to find the place that can bring Republicans and Democrats and Independents and all of us together.

I do think that the Cooper bill does have a real place in terms of this whole debate because it seems to be a place where this debate may well begin to emanate from and something we can build on.

I was struck as I was waiting yesterday to make a 1-minute statement on Japan at the number of Republicans who were saying that the Cooper-Grandy bill was nothing more than the Clinton bill, but just slightly different, and then I am struck by the people in our own party who say that Cooper is really nothing else more than the Michel bill, slightly changed.

Perhaps what that means is that we are just about in the center of the universe of things that we are talking about in the Congress, and I would hope that the committee would give it some credence as they proceed.

Chairman STARK. The gentleman has in many instances added a voice of moderation and wisdom to the committee's deliberation, and I think you are attempting to play that role and doing a very good job of it in this debate, and we will look forward to your continued participation. Thank you.

Mr. PAYNE. Thank you very much, Mr. Chairman.

Chairman STARK. Our next witness is Hon. Charlie Rose.

STATEMENT OF HON. CHARLIE ROSE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. ROSE. Thank you very much, Mr. Chairman. I have learned a great deal sitting here this morning listening to this extended debate about probably the most important vote I will ever make in the U.S. Congress.

The thing I would like to ask you to focus on as you go through this procedure is something that came to my attention rather starkly when I went through the recess that occurred just before this session came in and realized the concern of my people back home on how this plan will impact on each county in my district.

You and I worried a long time about where we are going to put our district office, so that we can give adequate service to the people. Well, think like that about health care. I am going to have to make a test, and I think most congressmen will have to make the test. Will county A, B, C, D, E, and F continue to have a fair level of service or will they be prejudiced in some way. All I want to say is you are getting very involved in the details as you have to do it, but every now and then, step back and consider the impact that this may have on rural America.

I am not here to endorse any particular plan, to look to your wisdom and what finally comes out, but Roy Rowland has an idea about the use of community health centers that has worked in my

district. I am not endorsing the way he would seek them to be paid for.

Chairman STARK. If the gentleman would yield, we have had some testimony, and we have worked in this subcommittee. The concerns of community health centers are identical for those of us who represent large urban or metropolitan areas and those of our colleagues who represent the most remote rural areas. It is a concern that I think, on a bipartisan basis, this subcommittee certainly has been concerned about, and we have tried at least in our previous Medicare legislation to find a way to provide access in both of these underserved areas.

Dr. Phil Lee, who is now at Health and Human Services, had provided extensive testimony about the administration's concern that any health plan recognized these unique areas. It is not all of an urban area, but there are parts where there is a problem, and it is not all rural America, but, indeed, selected parts with unusual circumstances who will need the opportunity to have special attention.

I can assure the gentleman that his concerns—and I am pleased he made the committee more aware of them—are shared here, and we will look forward to your counsel on that issue as we try and craft legislation that will meet, as he has heard, a variety of concerns.

Mr. ROSE. Thank you.

Mr. McDERMOTT. If I could just say, I think part of the reason why I look for support in rural areas as well as in inner cities for the single-payer plan is that those are both chronically underserved areas, and nobody is rushing out into the woods and nobody is rushing into the middle of the Bronx to deliver health care. So that is why I think we do have a lot of common ground, and we do share your concern.

Mr. ROSE. Thank you, and you can count on my support for the product that addresses these concerns. I want to help you get the 218 votes for what will work, and I commend Leon Panetta for his challenge before the Budget Committee. We need to get on with this. We need to do it, and I want to help be part of the solution and help eliminate the problems.

Thank you very much.

Chairman STARK. We have a 5-minute vote. The Chair will recess subject to the call of the Chair which will be sometime between 1:20 p.m., more like 1:30 p.m.

Thank you.

[Recess.]

Mr. McDERMOTT [presiding]. The next panel is Dr. Thomas Rice who is professor of public health at the University of California at Los Angeles; CONSAD Research Corp., represented by Wilbur Steger; John Lott, assistant professor of public policy and management, the Wharton School; Robert Helms of the American Enterprise Institute; Elizabeth McCaughey of the Manhattan Institute; and Leonard Schaeffer of Blue Cross of California.

So we will begin with Dr. Rice.

STATEMENT OF THOMAS RICE, PH.D., PROFESSOR OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA-LOS ANGELES, SCHOOL OF PUBLIC HEALTH

Mr. RICE. Thank you.

I am pleased to be here today to analyze how two bills, the Cooper-Grandy bill and the Thomas-Chafee bill, will affect access to care and health care cost. I should mention that I have not been involved in the development of any health care proposals now before Congress nor have I publicly expressed support or opposition to any particular bills.

With regard to access, I will begin with Cooper-Grandy. Compared to our present situation, I think it would improve access by making it possible for all poor people to afford coverage, by preventing insurers from denying coverage to those in poor health or charging them more, and by encouraging preventive services. But several access barriers would remain under the Cooper-Grandy bill.

First, employers would still not be required to contribute toward an employee's coverage. This has been the major reason why we have almost 40 million uninsured Americans. Individuals would be covered only if those chose to purchase it themselves. They might also continue to find themselves locked into a job that offers health benefits. In fact, some small employers may drop coverage they already provide and let low-wage workers fend for themselves with the aid of the premium subsidies.

Second, because the alliances would be comprised primarily of small firms, the uninsured, the self-employed, and those previous on Medicaid, they would have a relatively unhealthy mix of enrollees. This could result in premium levels that might be out of the reach of many small firms and individuals.

Third, the premium subsidies provided to those above the poverty level might not be sufficient to allow them to purchase coverage. I calculated that for a family of 4 with a \$25,000 income, they would have to spend about 10 percent of their income for just the cheapest plan, and that doesn't even count any of the cost-sharing requirements they would have to pay.

Fourth, with the exception of some preventive services, the specific benefits covered in the cost-sharing requirements are not specified in the bill. If the benefits ultimately chosen are modest and the cost-sharing requirements are high, then many people might lose benefits that they currently have.

Finally, people with higher incomes will find it much easier to purchase the more expensive plans, and that could result in two tiers of medicine. In the higher-income tier, plans might offer more flexibility, shorter waits, better-trained providers, easier access to specialists, and more technologies, but those in the lower tier might find accessing high-quality care to be difficult.

The Thomas-Chafee bill would also improve access to care. It would provide the same benefits as Cooper-Grandy. In addition, there would be universal coverage by the year 2005 if targeted savings in Medicare and Medicaid are met. Furthermore, individuals and families below the poverty level would not necessarily be limited to the cheapest plan available in their area. However, there still would be some barriers to access.

First, although universal coverage is a goal of Thomas-Chafee, it is not guaranteed. The individual mandate is only binding if there is enough money available from Medicare and Medicaid savings. In addition, the onus of paying for coverage is put on the individual rather than the firm, and as a result, millions of Americans may not be able to afford to pay for the coverage that they are required to buy.

Second, like the Cooper-Grandy bill, the health alliances under Thomas-Chafee would be comprised of relatively unhealthy individuals. This would tend to raise premiums, making it difficult for both individuals and small firms to afford coverage.

Third, although the benefits included are outlined in more detail than in Cooper-Grandy, there are still some important uncertainties. In particular, it is not stated what level of cost sharing will be required. This could be very harmful to lower-income individuals if the level chosen is high because they have more health problems.

I want to conclude with just a short discussion of cost containment. Managed competition is an untested concept, and in my opinion, there is no convincing evidence to indicate that it can successfully control health care cost. There are several reasons to doubt its effectiveness.

First, consumers, especially those who are in poor health and, therefore, attached to a particular provider, may continue to purchase costly fee-for-service plans.

Second, for a variety of reasons, HMOs have not been able to control growth in health care cost, and this problem is even more acute in the IPAs where the lion's growth of HMO enrollment is now occurring.

Third, providers may continue to wield considerable market power even with the formation of the health alliances. If the providers are allowed to join more than one alliance, each plan is going to have less clout, and this is becoming even worse now because so many provider groups are merging together to consolidate their own market power.

These problems will be accentuated under both bills. The health alliances are geared only to small employers, and then the enrollment is voluntary. The alliances, therefore, are likely to lack the necessary muscle to effectively bargain with the provider groups. This could be even a bigger problem under Thomas-Chafee, where the health alliances compete with one another.

Given the lack of evidence that managed competition can control health care costs, it may be necessary to impose overall budgetary limits. Although this is unattractive in some ways, I believe it is the only way to ensure that costs will be controlled in a managed competition environment. Other countries have operated such a system, but neither bill includes any such controls, and as a result, I would say that at the very best, the cost containment potential is untested.

Thank you very much.

[The prepared statement follow:]

**STATEMENT OF THOMAS RICE, PH.D.,
PROFESSOR OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA**

Mr. Chairman and Members of the Committee:

My name is Thomas Rice. I am a Professor of Public Health at the University of California at Los Angeles. I am pleased to be here today to provide an analysis of how two bills -- Cooper-Grandy (H.R. 3222) and Thomas-Chafee (H.R. 3704) -- will affect access to health care services and health care costs.

I would like to state at the outset that I have not been personally involved in the development of any health care reform bills now before Congress, nor have I publicly expressed support or opposition to any particular bill.

I will begin with a discussion of how these bills are likely to affect access to care, and conclude with an analysis of their cost containment potential.

ACCESS TO CARE

Cooper-Grandy

Compared to the present situation, the Cooper-Grandy bill would improve access to health care services. I am impressed with several aspects of the bill:

- All people below the poverty level would be able to afford health insurance coverage;
- Insurance companies would be prevented from denying coverage to individuals in poor health, and could not charge sicker people more; and
- Preventive services would be encouraged.

There would, however, continue to exist several barriers to access. First, as is the case today, employers would not be required to contribute towards an employee's health insurance coverage. This has been the major reason that we have almost 40 million uninsured people in the country. Without employer contributions, an individual and his or her family would be covered only if they chose to purchase it themselves. In fact, some small employers with low wage workers might choose to drop the coverage they already provide, letting their workers instead obtain coverage individually with the aid of the premium subsidies provided by the federal government to those with incomes below 200 percent of the poverty level.

Second, because the alliances would be comprised primarily of small firms, the uninsured, the self-employed, and individuals previously on Medicaid, they would have a relatively unhealthy mix of enrollees. This would result in premium levels that might be out of the reach of many small firms, and also make it difficult for individuals to afford to purchase coverage even with the help of premium subsidies.

Third, individuals might still find themselves "locked" into a job because it offers health benefits. Since employers are not required to contribute to their employees' health insurance plans, changing jobs could become very costly, particularly to a person whose income is just above the threshold for receiving premium subsidies.

Fourth, the premium subsidies provided to individuals above the poverty level might not be sufficient to induce them to purchase coverage. Suppose that a family of four had an income of 75 percent above the poverty level -- about \$25,000. If the lowest cost plan in an area would cost \$4,000, they would have to spend \$2250 ($\$4,000 \times .75$) towards the premiums of that plan, almost 10 percent of their income.

Fifth, with the exception of some preventive services, the specific benefits to be covered, and patient cost sharing requirements, are not specified. Rather, they will be determined after passage by the Health Care Standards Commission. This is worrisome because budgetary constraints might force the Commission to opt for a relatively narrow set of benefits, along with relatively high cost sharing requirements. This could lead, in turn, to many people losing benefits for which they currently have coverage.

Sixth, it is not clear that adequate funding will be available to pay for long-term care services -- particularly nursing home care. Medicaid now pays for over 40 percent of the cost of nursing home care, but this component of Medicaid would be eliminated and responsibility would be transferred to the states. While some states would have sufficient funding available to shoulder this burden because the federal government will be subsidizing the purchase of insurance by low-income persons, one worry is that other states -- especially those with a higher proportion of severely disabled elderly -- will not be able to adequately fund long-term care. In addition, this change would undo the many consumer protections guaranteed to nursing home patients during the late 1980s that were tied to the Medicaid program.

Finally, people with higher incomes will find it much easier to purchase more expensive health plans, which in turn could result in segmentation of the insurance market into two tiers. In the higher income tier, plans might offer more flexibility, better trained providers, easier access to specialists, and more technologies. In contrast, those in the lower tier might have difficulty finding a nearby provider willing to treat them, experience longer waits, and not have access to the best providers and technologies. Using the earlier example of the family with income 75 percent above the poverty level -- even if they could afford the \$2,250 in premiums for the lowest cost plan, it is extremely unlikely that they could afford to pay, say, \$3,750 for a plan costing \$5,500.

Thomas-Chafee

Compared to our current health care system, the Thomas-Chafee bill would also improve access to care. In particular, it would provide the same advantages discussed earlier with respect to the Cooper-Grandy bill. It also has two other advantages:

- There would be universal coverage by the year 2005 if specific savings from Medicare and Medicaid are met; and
- Individuals and families below the poverty level would not necessarily be limited to the cheapest plan available in their area. Rather, they would receive subsidies equal to the mean premium averaged over the cheapest half of all plans. Thus, they might receive coverage that allows them to be better integrated into "mainstream" medical care.

Both of these elements are extremely important and should not be overlooked when assessing the desirability of this bill. Nevertheless, there remain some barriers to access.

First, although universal coverage is a goal of the Thomas-Chafee bill, it is not guaranteed. This is because the individual mandate upon which it is based will be binding only if there is enough money available to fully fund specified subsidy levels for low-income persons. If Medicare and Medicaid savings are not as great as hoped, then benefits could be reduced or the eligibility for and/or size of the vouchers could be tightened; as a result, universal coverage could be delayed or put off indefinitely.

Whether growth in Medicare spending can be reduced from 12 to

7 percent per year is anyone's guess. The most likely way this could be achieved is by reducing provider payments. But hospitals report that they are already losing 10 cents on the dollar for treating Medicare patients, and physicians now receive only about 70 percent as much for their Medicare patients as their privately insured patients. It is not clear how much more Medicare provider payments can be cut and still be able to assure adequate access to care for the elderly and disabled population.

Second, as the case of Cooper-Grandy, the health alliances under the Thomas-Chafee bill would tend to have relatively unhealthy enrollees because they would be primarily comprised of small firms, the uninsured, the self-employed, and individuals previously on Medicaid. This would tend to raise premiums, making it difficult for both individuals and small firms to afford to purchase coverage.

Third, the onus of financing coverage is put on the individual rather than the firm. Without contributions from their firms, millions of Americans may find it financially difficult to afford health insurance coverage. Subsidies will help, but the bill does not guarantee the size of these subsidies since the magnitude of Medicare and Medicaid savings is unclear. Furthermore, subsidies are to be phased out at 240 percent of the poverty level. Thus, a family with an income of, say, \$35,000 could be forced to spend well over 10 percent of total income for a health insurance policy without any help from an employer, or the benefit of a government subsidy. And this does not even include the financial burdens that would be caused by higher cost sharing levels. Millions of families are likely to find these increased premium and cost sharing payments to be an onerous burden.

Fourth, the same issue of "job lock" discussed above could also occur under the Thomas-Chafee bill -- in fact, it could become even more severe. Because employers are not required to contribute towards an employee's coverage, some individuals will find it financially painful to move from an employer that offers coverage to another that does not. This would be accentuated by the individual mandate -- since individuals would be required to purchase coverage, many would feel forced to stick with an employer that helped them make such payments.

Fifth, although the benefits to be included are outlined in more detail than in Cooper-Grandy, there are still some important uncertainties. In particular, it is not stated what level of cost sharing will be required in both the standard and the catastrophic benefit packages. This could be particularly harmful to lower income individuals, who tend to have more health problems.

Finally, as in the earlier discussion, those with higher incomes will find it easier to purchase more expensive plans, resulting in segmentation of the insurance market. This problem is likely to be somewhat less extensive than with Cooper-Grandy, because subsidy levels are based not on the lowest cost plan in an area, but on the mean premium averaged over the cheapest half of all plans.

COST CONTAINMENT

Because Cooper-Grandy and Thomas-Chafee both rely on managed competition to control health care costs, most of my remarks apply to both. A more detailed discussion of the points I will make appears in an article I jointly authored with E. Richard Brown and Roberta Wyn, entitled "Holes in the Jackson Hole Approach to Health Care Reform," that appeared in the Sept. 15, 1993 issue of the *Journal of the American Medical Association*. I have attached a copy of this article to my written testimony and ask that it be included in the Record.

Managed competition is an untested concept. In my opinion,

there is no convincing evidence to indicate that it can successfully control growth in health care spending. There are several reasons to doubt the effectiveness of managed competition in controlling health care costs. They include the following:

- Consumers -- particularly those with health problems and who are therefore attached to particular providers -- may continue to purchase costly fee-for-service health plans that provide them maximum flexibility.
- HMOs have shown little success controlling the overall rate of growth in health care costs. This is due in part to the fact that they attract a favorable mix of patients, leaving sicker ones to the unmanaged fee-for-service sector. Nor have they shown any ability to control the use of expensive technologies. The problem is even more acute in independent practice associations (IPAs), in which the vast majority of HMO growth is occurring. In many parts of the country, the only types of HMOs that can be supported with the population base are IPAs.
- Providers may continue to wield considerable market power even with the formation of health alliances. If, as is the case in all major bills before the Congress, providers are allowed to join more than one health plan, then each plan will have less clout. This problem is becoming more pronounced now that so many provider groups are merging together. In doing so, they hope to be able to keep their prices higher and the profit margins up.

The problems just mentioned will, in my opinion, be accentuated under both the Cooper-Grandy and Thomas-Chafee bills. Under both, health alliances will be geared only to small employers, and even then, enrollment through the alliances will be voluntary. Thus, the purchasing alliances are likely to lack the necessary muscle to effectively bargain with provider groups. This could be even a greater problem under Thomas-Chafee, where health alliances may compete with each other. Not only will this weaken their bargaining position, but it could also result in competition among alliances for the best risks.

The example usually given of a successful working model of managed competition is the California Public Employees' Retirement System (CalPERS). But this is not a convincing model because CalPERS members make up only a small portion of most health plans' total enrollments. As a result, plans have been able to make price concessions to CalPERS and still maintain revenues by charging other buyers more. Furthermore, the program is not generalizable to the rest of the country because its members are all employed and tend to be fairly well paid, it does not offer a fee-for-service option, and it operates in an area with tremendous HMO competition. There is also evidence that the non-HMO (i.e., PPO) plan has experienced adverse selection.

Given the lack of evidence that managed competition can control health care costs, it may be necessary to impose overall budgetary controls over the U.S. health care system. Although unattractive in many ways, I believe that this is the only way to ensure that costs will be controlled. Such systems have operated successfully in other countries and might also work in the United States. Neither bill, however, includes any such controls. As a result, their cost containment potential is at the very best, untested.

Thank you very much.

Caring for the Uninsured and Underinsured

Holes in the Jackson Hole Approach to Health Care Reform

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MANAGED competition is synonymous with market-oriented health care reform. Those who coined the phrase, the Jackson Hole Group,¹ have been identified, incorrectly, by the *New York Times*² as the brain trust for the Clinton administration's reform proposal. Many medical industry groups have participated in developing the Jackson Hole version of managed competition, including major insurance companies, the American Medical Association, the Pharmaceutical Manufacturers Association, and large health maintenance organizations (HMOs). About the only significant interest groups that have not expressed support for the concept are those representing consumers. In this article, we critically assess the Jackson Hole Group's proposal to control health spending and provide access to quality health care.

Boiled down to its fundamentals, the Jackson Hole approach to managed competition requires three major changes in the US health insurance system. First, regional health insurance purchasing cooperatives (HIPCs) are formed to manage the marketplace for health care coverage, especially for small firms and individuals. Second, employers and HIPCs contribute the same amount of money for coverage regardless of which plan a consumer chooses. This provision requires limiting the tax excludability of health benefits to the rate charged by the least costly qualified health plan, so that premium payments above that level would be with after-tax dollars. Third, to level the playing field among all health plans, new rules make it more difficult for plans to avoid enrolling high-risk individuals.

This critique focuses on the Jackson Hole model of managed competition; it applies to other versions of managed

competition only to the extent that they share important features with this approach.

THE JACKSON HOLE APPROACH WILL NOT CONTROL HEALTH CARE EXPENDITURES

Jackson Hole advocates argue that their approach to health care reform will help control health care expenditures by making consumers more cost-conscious purchasers of health insurance and health care services. The Jackson Hole approach assumes that savings will be generated largely through greater enrollment in HMOs. Providers, in turn, will have to compete among themselves to be selected as members of health plans by charging less and/or providing services in a cost-effective manner.

There are three reasons, however, why the Jackson Hole approach is unlikely to succeed in controlling US health care expenditures: (1) consumers—particularly high users—will continue to purchase expensive health plans; (2) greater enrollment in HMOs will provide few savings; and (3) providers will continue to have considerable bargaining power in their dealings with health plans.

Consumers Will Continue to Purchase Rich Benefit Packages

One of the central assumptions in this approach is that consumers will not readily spend their own (after-tax) dollars to purchase relatively expensive health care coverage. Embedded in this argument are two suppositions: consumers are responsive to premium differences among plans, and many will be satisfied with the minimum required set of benefits. Neither of these assumptions is likely to be true.

The economic evidence on how responsive consumers will be to differences in premiums is embodied by the economic concept of the price elasticity of demand for health insurance. This is defined as the percentage of change in the amount of insurance purchased divided by the

percentage of change in premiums.³ Admittedly, previous research on these elasticities provides only indirect evidence concerning the Jackson Hole approach because the latter is likely to result in a different set of insurance choices for consumers.

The literature reports a great deal of uncertainty concerning the magnitude of the price elasticity of demand for health insurance. Estimates from some of the more sophisticated studies vary greatly, from as little as -0.16 to as much as -2.8 .⁴ The Congressional Budget Office reports, however, that when similar methods are used to compute these elasticities, the results from most studies fall into a much narrower range (internal memorandum, March 17, 1993). It estimates that the price elasticity of demand for health insurance equals about -0.2 in the short run, and -0.6 in the long run. (The short run is defined as the period over which a group, such as organized labor, cannot renegotiate its collective bargaining contract—typically, about 2 years.) Thus, although consumers would be expected to respond somewhat to premium differences when choosing their health plans, the magnitude of this response does not appear to be particularly great.

Even if consumers as a whole were responsive to premium differences, this still might not result in substantial cost savings. This is because the people most likely to respond to premium differences are those who are relatively low users of service. One percent of the US population is responsible for a full 30% of health expenditures; 2% account for 41%; and 10% are responsible for 72%.⁵ High users, who tend to have significant health problems, are likely to have a much stronger interest in staying with their current physicians. As a result, they would not be easily swayed to switch health plans even with the prospect of lower premiums. This is especially true of a switch to a group or staff model HMO—the health plan of choice for the Jackson Hole Group—where the

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patient is locked into the plan's own provider panels.

High users of health services will also be inclined to purchase plans with more comprehensive benefits, further undermining the Jackson Hole strategy to control total health spending. Alternatively, if benefits were completely standardized so that health plans could not include any extra types of benefits—as some Jackson Hole advocates, such as Enthoven,⁸ recommend—individuals could purchase supplemental policies (not unlike current Medigap insurance, which is owned by 70% of the elderly) to cover any gaps and, possibly, cost-sharing requirements.

No direct evidence is available to indicate the extent to which the public will wish to purchase benefits above the basic plan. The only research that sheds much light on this issue comes from the RAND Health Insurance Experiment.⁷ Although the experiment covered almost all services, copayments were required. Participants were asked whether they wished to purchase supplemental insurance that covered all or part of their out-of-pocket expenses; 60% said they would. There was also a substantial amount of adverse selection; families that anticipated facing higher health expenditures were much more likely to want to purchase supplemental coverage.

Under managed competition, the development of new technologies is likely to create further upward pressures on the benefits package. Although very discretionary and perhaps experimental services would not be covered, they could be obtained either by purchasing a more comprehensive health plan or by paying for these services directly with out-of-pocket dollars. Over time, however, consumers and providers will insist that many expensive new technologies and services be included in the basic plan for the simple reason that someone else will be paying the lion's share of the costs. Examples could include the dramatic—an acquired immunodeficiency syndrome vaccine or a drug treatment that slows the loss of mental capacity or even reversed Alzheimer's disease—or the more pedestrian, such as ultrasounds with better resolution.⁹

The types of pressures that will be faced by government can be seen by examining the extent of state-mandated health benefits. State governments had enacted more than 730 mandated health insurance benefits by 1988.¹ The same interest groups that were able to get state mandates approved are almost certain to fight hard to make sure that their particular type of coverage is included in any basic plan.

Greater Enrollment in HMOs Will Do Little to Control Expenditures

A common thread in the writing of the Jackson Hole Group and other advocates of managed competition is the reliance on group or staff model HMOs.^{1,10} But there are several reasons why greater enrollment in HMOs will do little by itself to control health care expenditures. First, most people moving into HMOs will join independent practice associations (IPAs). In 1990, about 60% of individuals in HMOs were enrolled in individual or network model IPAs,¹¹ and this trend is becoming more pronounced.

Between 1988 and 1990, 77% of HMO enrollment growth was accounted for by individual or network IPA plans.¹² Available evidence concerning the cost-containing potential of IPA is mixed. Although recent findings reported in JAMA from the Medical Outcomes Study¹³ do report some cost savings, most other analysts, including the Congressional Budget Office, have found little evidence of savings.^{12,14}

Second, consumers who join group or staff model HMOs tend to be healthier; for such persons, managed care offers the fewest cost savings because they have less potential to need large volumes of services. Although many of the rules of managed competition are supposed to reduce the amount of favorable selection into HMOs, selection bias may continue to be a problem, and in fact, insurers have a bevy of such techniques available, many of which could still persist even under the Jackson Hole approach.¹⁵ The Federal Employees Health Benefits Program (FEHBP) and the California Public Employees' Retirement System (CalPERS) provide some evidence for this, although the comparisons to the Jackson Hole approach are not directly applicable because neither of these programs risk-adjusts and because both include retirees in their insurance pools. The FEHBP's high-option service and indemnity plans have attracted a much higher proportion of retired people and high-risk people than the HMOs.¹⁶ The same is true of CalPERS—which is often touted as a prototypical Jackson Hole model—where the statewide preferred provider option, which has the most flexible and extensive benefits of the health plans offered, has experienced adverse selection relative to the HMOs.¹⁷

The Jackson Hole approach attempts to deal with any remaining problems of selection bias by "risk adjusting" contributions. That is, plans with sicker enrollees will get higher payments, although these proposals are silent on ex-

actly what the formula would look like. Many efforts have been made to find factors that are good predictors of future utilization; one study¹⁸ reviewed more than 40 such efforts published through 1985. Factors examined include sociodemographic factors, some clinical and self-assessed health measures, daily activity limitations, and prior utilization and costs.

Perhaps the best of these variables for explaining future health care utilization is past utilization.¹⁹ It could therefore be argued that plan contributions to health plans should be based in part on previous utilization levels of enrollees. Unfortunately, this approach is inherently inflationary. If plans are compensated more in subsequent years if enrollees use more services now, there would be an incentive to increase current utilization levels, which in turn would result in higher expenditures. Researchers are using some of the variables mentioned in the previous paragraph to develop more powerful formulas that are not inherently inflationary.²⁰ But until the state of the art is far enough along to take away plans' advantages from obtaining a favorable selection of enrollees, purchasing cooperatives will have to use less technically sophisticated means of adjusting payments to plans.

Third, although HMOs cost less than fee-for-service plans for a particular array of benefits, they have not been successful in controlling the rate of increase in health care expenditures. This has been shown to be the case consistently for the last 30 years.²¹⁻²³ Part of the problem is due to HMOs' inability to control the rate of technology diffusion and other input costs. If HMOs are to compete with fee-for-service medicine, they must provide the same types of services that make their physicians feel that they are providing state-of-the-art medicine and their patients believe that they are receiving the best medical care possible. In this regard, Newhouse²⁴ has stated that "whatever is driving up costs in fee-for-service medicine has been driving them up in HMOs as well. Technology is a factor that applies to both." Of course, if approaches such as Jackson Hole result in a much higher rate of HMO enrollment than previously, then future experience might differ from the past, as HMOs compete more against each other than against fee-for-service plans. But at this point, such a scenario is speculative.

Finally, in most parts of the country there is not a sufficient population base to support adequate HMO competition. Kronick et al¹⁰ recently conducted an analysis that assumed that three com-

peting health plans were necessary to ensure minimally adequate competition in an area. They found that only 42% to 63% of the population lives in areas that could support three or more HMOs. Jackson Hole proponents argue that in the majority of rural areas, managed competition would work through the use of flexible health plan arrangements (eg, competition among small primary care facilities or among primary care providers). But they do acknowledge that there are settings, and in fact whole states (eg, Wyoming and Montana), where the approach may not work and would need to be replaced by a "managed cooperation" approach.²⁵

Whether or not one accepts these numbers, it is clear that the Jackson Hole model would not be effective in a large proportion of the country. Furthermore, just because the population exists does not ensure that the minimum number of HMOs will enter the market. Even when there is a sufficient population base to support a number of HMOs, it may take years for enough group or staff model HMOs to enter the market and achieve adequate enrollments.²⁶

Providers Will Continue to Have Considerable Bargaining Power

One of the linchpins of the Jackson Hole approach is that health plans will have considerable leverage over providers. Because it is assumed that plans that are too costly will not be chosen by consumers, the only way for plans to survive is to exercise strong bargaining power over provider groups. And since being a member of a health plan is the only game in town, providers will have to play ball or else lose most of their business. This scenario may not be realistic, however, for the following reasons.

First, if providers join multiple plans—which purportedly will be allowed under the Clinton administration's proposal—then plans will continue to have little effective bargaining power. Most advocates of managed competition recognize that little is gained when providers contract with large numbers of managed care plans.^{10,27} As the number of health plans increases, each has less market power over individual providers, particularly when providers become members of more than one plan. This places plans at a disadvantage in bargaining with providers, and the price they receive may not be as low as it would be otherwise. It is, therefore, surprising that most managed competition proposals, including Jackson Hole, do not explicitly control the number of competing plans or the number of plans with which individual providers may contract.

Although the HPCs or other bodies certify plan eligibility, in most proposals any qualified plan may market itself.

An example of this problem is the experience of preferred provider organizations (PPOs). In 1988, the typical insurer-sponsored PPO had 155 000 eligible participants, and 13 000 physicians.²⁸ Thus, on average, each physician had only 11 members from a particular PPO, who may not have even used the PPO network. The PPOs therefore have little bargaining power over providers since they are responsible for so little of each provider's practice. In fact, recent studies²⁹⁻³² have almost universally concluded that PPOs either do not reduce health care expenditures or even raise them.

The second problem is that providers may respond to the formation of HPCs by consolidating into larger practices to obtain countervailing market power. This appears to be what has occurred in Minnesota. As a reaction to the increasingly competitive nature of the public and private health insurance market during the 1980s, practitioners and "hospitals have organized into bigger chains to give themselves the clout to negotiate."^{33,34} This countervailing market power has allowed providers to raise their prices and keep their margins up.³⁴ Jackson Hole advocates offer no clear solution to this problem.

THE JACKSON HOLE APPROACH WILL NOT ENSURE ACCESS AND QUALITY

Advocates of the Jackson Hole approach argue that it will improve access and quality of care for several reasons: universal coverage would be assured, with the poor and near-poor receiving subsidies toward purchasing health coverage; insurers would no longer be permitted to deny coverage or charge more to people in poor health; more people would be offered a choice of health plans than currently have such a choice; and the poor could receive coverage from the same plans as the nonpoor. Quality would also improve as plans compete with each other to provide the best product, medical outcomes, and satisfaction per premium dollar. This kind of competition would be facilitated by requiring plans to disseminate information about these outcomes to prospective and current enrollees.

Conversely, it can be argued that access and quality problems would persist under managed competition. By relying on price competition among plans and providers, access and quality could be jeopardized through the segmentation of the market into two tiers. One tier would be composed of lower-income en-

rollees who, for economic reasons, were forced to join the least costly plan in an area; the other tier would include almost everyone else. A discussion of these issues follows.

Limited Access for Low-Income People

Capping employer payments and government subsidies to health plans at the rate charged by the lowest-cost certified plan in an area would, in practice, restrict the lower-income population to these basic plans. This is not so much a problem in the existing programs that Jackson Hole advocates frequently point to—the Minnesota State employees program, CalPERS, the FEHBP, and other large public-sector employers—because nearly all employees in these groups are paid sufficient wages to afford some choice. The same cannot be said for people employed in low-wage occupations or industries.

State-level studies for Massachusetts and Vermont estimated that, after taking account of typical essential monthly expenses, families below 200% of the poverty line had little or no disposable income available for sliding-scale contributions to health insurance premiums.³⁵ Another study found that lower-income families' spending on health insurance is much more influenced by the price of the plan: price elasticity estimates for health insurance were twice as high for families with incomes between \$15 000 and \$25 000 as for those with incomes of more than \$40 000 (-0.14 vs -0.06); for families with incomes less than \$15 000, elasticity estimates were six times higher (-0.39) than for those with incomes of more than \$40 000.³

Thus, persons with family incomes below 200% of the federal poverty level are unlikely to be able to afford premium surcharges. Using this standard, 80 million people—32% of the entire population—will be able to "choose" only among basic plans (unpublished analysis of March 1991 Current Population Survey). Market choice requires the financial means to choose, but the Jackson Hole approach would limit the choice of lower-wage workers and other lower-income persons to basic plans.

If low-income people are financially restricted to basic plans, differentials in premium charges between plans would result in segmentation of the market. Although Jackson Hole advocates assume that some plans will market to persons who cannot afford out-of-pocket premium charges, it is likely that most plans would prefer to market to a more affluent market niche where profit margins may be higher. These plans would entice middle- and upper-income groups

to pay more of their after-tax income for more choice of physicians, shorter waits for appointments with primary care physicians and specialists, more conveniently located physicians, hospitals, and pharmacies, and/or broader coverage. Market segmentation would adversely affect people who are unable to afford more than a basic plan. They would find that there are not enough plans with enough capacity willing to participate; they would find few providers willing to serve them; and they would have less access to specialty care and expensive medical technologies.

Low-income persons are likely to have a difficult time finding plans in which they can enroll because few plans may choose to market themselves at the most affordable basic plan rates. This has been the experience with managed care in the Medicaid program. A recent survey found that only 22% of HMOs were participating in the Medicaid program; low participation rates by plans are due mainly to low premiums paid by Medicaid, discontinuous Medicaid eligibility of enrollees, and marketing problems.^{7,38}

In addition, people who can afford only a basic plan may have poorer access to health services and poorer quality care compared with more affluent persons. Although all plans would be required to provide a comprehensive benefit package, enrollees in basic plans may find it difficult to obtain many of the services that are covered by the plan. The more limited economic base of low-cost plans would restrict their ability to match the fees paid by higher-cost plans. Many providers would refuse to contract with low-cost plans, relegating enrollees in basic plans to a limited-access and sometimes lower-quality market niche similar to the situation in which Medicaid patients find themselves.^{39,40} Many Medicaid programs contain benefit packages that are far more generous than those offered by private industry, but Medicaid beneficiaries have difficulty obtaining these services from willing providers.⁴¹ People in low-cost plans would have coverage, but actually getting covered services may require a trip across town to the nearest contract provider, waiting weeks for an appointment, or being restricted to a group of marginal physicians, hospitals, and other providers that contract only with basic plans.

Plans would also vary in their access to specialty care and expensive technologies. More expensive plans, which middle- and upper-income people would have the resources to choose, are likely to provide somewhat easier or more timely referrals to specialists. Lower-cost plans, to which lower-income people would be limited, would be more

likely to restrict use of such services even when they are necessary and effective or contract with specialists who are less experienced and less skilled. Patients in more expensive plans would be more likely to receive costly procedures, such as coronary artery bypass surgery or hip replacements when these are appropriate, than enrollees in lower-cost plans. This has been the experience of Medicaid patients, who are now covered by a program that pays physicians and hospitals less than they receive for treating other patients and who receive fewer such services and procedures than privately insured patients, often with adverse effects on their health status.⁴¹ This difference in access between basic-premium plans and those that impose a premium surcharge would perpetuate differences in access to health services based on socioeconomic status rather than on medical condition and appropriateness only, continuing fundamental inequities in access to care.

These practices would be especially detrimental for persons with disabilities or chronic conditions who have low incomes and cannot afford more than the basic plan premiums. Most persons with disabilities have a "narrow margin of health" that "must be carefully maintained if medical problems are to be avoided."⁴² If inadequately or improperly managed, such conditions may deteriorate rapidly and result in otherwise avoidable hospitalization, as well as time lost from work or school, increased disability, or even death. Prompt access to a primary care practitioner who is knowledgeable about the multiplicity of factors that accompany a disability and that influence the person's health status is essential in order to avert major medical problems and rapid decline in functional ability.⁴³

The risks of such delays are likely to be higher in basic plans, due to the combination of financial incentives of capitation payment (which makes each referral a cost to the plan) and the limited market choice of plans that may be available at the basic plan premium. There is considerable evidence, from research findings and anecdotal accounts, that low-income persons with chronic conditions do not fare well in managed care plans, such as HMOs.^{44,45} Primary care case management involves a physician or other practitioner coordinating care for a person, but it also makes the case manager the gatekeeper to control use of expensive services. The HMOs are likely to emphasize the gatekeeping role; they may delay or withhold referrals to specialists and other services that would cost the plan money out of its pool of prepaid premiums.^{45,46} Although special-

ty care and expensive procedures are undoubtedly overused, simply tightening the reins on utilization—whether by restrictive practices in HMOs or by imposing deductibles and coinsurance in fee-for-service plans—reduces use of appropriate and effective services, as well as inappropriate care.⁴⁷ The greater need for services by people with chronic health problems often leads to considerable friction between them and their managed care plan.

Restrictive practices do not seem to adversely affect most people in good health or those with only minor health problems, but these practices pose special risks for people whose health is poor. In the RAND Health Insurance Experiment, low-income individuals and families who were in poor health at the start of the study and who were randomly assigned to a large, well-established HMO had, by the end of the experiment, more bed-days per year due to poor health and more serious symptoms than those assigned to the fee-for-service plan with no patient cost sharing, and they had a greater risk of dying than those in the fee-for-service plan with cost sharing.⁴⁸ These findings suggest that low-income persons in poorer health whose incomes limit them to a basic plan may have poorer outcomes than those who have access to more costly and better plans.

Potentially Poorer Quality Health Services

Jackson Hole advocates assume that HIPCs would be the guardians of both access to health services and the quality of plans and services.⁴⁹ Health plans must agree to report medical outcomes and other quality assessment data to the HIPC and the public. Such information can assure the quality of plans and medical care provided by plans only if the HIPCs have a strong interest in monitoring and enforcing standards and if the covered population has effective market choice among competing health plans.

An HIPC's costs would be determined by the per capita cost of the basic plan; its total financial liability would be limited to this per capita premium multiplied by the number of persons in the area. The quality of care and access available in basic plans would likely be secondary to their cost. Enforcing quality standards depends on the HIPC identifying those plans that do not comply and, for those that fail to improve, being willing to use a "club"—freezing the errant plan's enrollments or premium rates or terminating the plan's contract with the HIPC. But for the HIPC to be willing to terminate contracts with the low-

est-cost plans would require the HIPC to pay a higher basic plan premium, a policy they would be more likely to adopt for a politically influential constituency than for the lower-income population that will predominate in the lowest-cost plans.

It is possible to pressure public agencies to take seriously the needs of enrolled populations. Oregon's Medicaid managed care program has avoided several of these problems through more rigorous enforcement of standards.⁵⁰ But vigilant oversight is not the rule when it comes to low-income communities. Low-income populations tend to be less organized, participate less in the political process, and have less personal political influence than more affluent communities. Programs and services targeted to low-income people are therefore often the first victims of budgetary axes in a fiscal squeeze.⁵¹ Advocacy for the interests of low-income people is sporadic and only occasionally successful.

Giving consumers market freedom to take their business elsewhere could offer some protection against being locked into unresponsive, low-quality plans, but this freedom may not be available to low-income families and individuals. If the HIPC is not vigilant in enforcing quality standards and is excessively focused on the bottom line, some health plans may try to capture the basic plan market by deliberately offering bids below the level necessary to provide adequate access to quality services. Some unscrupulous plans may skim excessive profits, leaving insufficient funds to provide reasonable access or quality. If the HIPC is not exercising appropriate oversight of plans, market choice could enable better-off enrollees to escape from poor-quality plans and enroll in better ones. Although middle- and upper-income groups are likely to have economic choice among alternative plans, people restricted by their incomes to basic plans would find themselves stuck in the system's bottom tier where they will endure poor access and questionable quality of care.

THE OVERALL IMPACT OF THE JACKSON HOLE APPROACH

We have described a number of specific problems with the Jackson Hole approach. Here, we provide a broader and more dynamic picture of how consumers, employers, and government are likely to be affected by the implementation of this model. The scenario we envision would look like the following:

For all of the reasons discussed herein, the system will result in little if any savings in health care expenditures. (This conclusion is not just ours but also

that of the Congressional Budget Office, which has stated with regard to the Conservative Democratic Forum's managed competition proposal [HR 5936], that "after a few years, [the bill] would leave national health expenditures at approximately the same level they would reach otherwise."⁵² Although expenditures are likely to continue to rise at the same rate as in the past, government's ability to subsidize health care purchases for the poor and near-poor probably cannot rise as fast as the overall increase in health care premiums. As a result, a major gap will quickly emerge between the plans being offered.

The lowest-cost plans in an area will tend to be ones that are the least desirable but which are the only ones affordable for the poor and near-poor. They will have limited provider networks that may be geographically inconvenient, provide only the most basic services required, provide the least choice of physicians and hospitals, make it difficult to obtain specialist care and new technologies, and have the least thorough quality assurance programs. We thus anticipate segmentation of the market for health plans and health services, with more costly plans providing more accessible and often better-quality services for their enrollees—in short, a continuation of two-tier medicine under the Jackson Hole approach.

By offering more prestigious physicians and hospitals higher payment rates than low-priced plans could afford and by making state-of-the-art technologies and services accessible, health plans that cater to the more affluent population would put upward pressure on health care prices and expenditures. Providers would tend to restrict their services to particular market niches, with most hospitals and physicians preferring to serve patients whose plans pay the higher rates and offer the most opportunity to provide state-of-the-art medicine. This pressure driving up the costs of more expensive plans will, in turn, drag up the costs of basic plans because they must buy services and labor from the same markets as the more expensive plans.

Such a scenario will have a number of undesirable consequences for consumers, employers, and government. Most consumers will see their out-of-pocket payments toward premiums continue to rise quickly. Since employer and government contributions would be linked to the lowest-cost plans, those opting for the higher-tier plans will have to pay for them with their own, after-tax dollars. Although this is one of the purposes of Jackson Hole reforms, the originators of the concept believe that in-

cluded among the cheaper plans will be the Kaiser Permanentes of the world—high-quality, low-cost group or staff model HMOs. In contrast, we believe that such plans will end up competing for more affluent patients, leaving the poor and near-poor in plans that may skimp on quality.

This financial burden on those choosing to opt out of the cheapest plans will not only increase over time, it is likely to be very unpredictable. Because employer and government contributions will be tied to the lowest-cost plan in an area, out-of-pocket premiums for higher-end plans may jump wildly from year to year, depending on the vagaries of what one plan in a particular area decides to charge for basic coverage. If a plan lowers its price to try to increase its market share, two things could happen: it may not provide what it promises to the less affluent people who choose that plan, and it will result in a ballooning of out-of-pocket premiums for everyone else living in that area.

Employers and government are also likely to be burdened under this scenario because they will find it difficult to control their own health care spending. As all health expenditures continue to rise, employer and government health spending would be pulled up. This will result in strong pressures to increase their contribution levels to the basic plans so that (1) the quality of the basic plans is acceptable, and (2) those who choose more expensive plans will not have to pay as much in out-of-pocket premiums. Such a dynamic would require increased taxation for subsidies or add to the deficit. It also would undermine employers' desires to stem rising health spending.

This dynamic results in large part from Jackson Hole advocates' heavy reliance on making people cost-conscious consumers of health plans in order to control the growth of health spending. Advocates propose to limit employers' contributions and the tax excludability of health benefits in order to make consumers bear an increased share of the cost for choosing health plans that are more expensive than the lowest-cost plan. Relying on enrollees' cost consciousness is a fundamentally weak strategy, in part because people, especially those who are in poorer health, are likely to buy additional coverage to protect themselves from excessive costs when they need health services. In addition, the intense focus on controlling patients' demand for health services avoids addressing supply-side factors that are necessary to control the upward spiral of health spending. The central role of providers in stimulating demand for health

services is a critically important focus for effective efforts to control expenditures—and it is a focus that is largely absent in the Jackson Hole approach.

CONCLUSIONS

This critique has focused on the potential problems of the Jackson Hole Group's managed competition proposal. Major modifications would be required to address these criticisms. Some of these—for example, imposing a global budget on HIPCs, limiting the amount of supplemental insurance consumers need and are allowed to buy, and regulating new investment in facilities and expensive equipment—would control expenditures more effectively. Others—such as subsidizing low-income people

to purchase higher-cost plans—would enhance access to quality care. Some—such as capping the differential between the highest- and lowest-cost plans in an area or prohibiting plans from charging premiums in excess of a uniform rate set (or negotiated) and paid by the HIPC—would control expenditures and improve access.

The proposal by President Clinton's Task Force on National Health Care Reform incorporates some basic elements of managed competition but, wisely, in our opinion, reportedly departs from the Jackson Hole approach in important ways. Among other departures from the Jackson Hole model, the President's proposal may include global budgets, allow HIPCs to be more aggressive negotia-

tors with health plans and providers, and allow state options for all-payer rate setting and single-payer systems.

Any health care reform proposal, if it is to succeed as policy, must effectively control expenditures while improving access to health services and taking steps to enhance quality of care. At the same time, it will need to restructure health care financing in ways that are uniquely suited to the institutional and cultural complexities of American society while garnering enthusiastic popular support that can pressure a Congress, torn in different directions by special interests, to enact the reform. This is a tall order for any reform, and, in our analysis, the Jackson Hole approach does not meet the test.

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Mr. McDERMOTT. Thank you.
Mr. Steger.

STATEMENT OF WILBUR A. STEGER, PH.D., CHAIRMAN OF THE BOARD AND PRESIDENT, CONSAD RESEARCH CORP., PITTSBURGH, PA.

Mr. STEGER. The bases of this testimony are several reports that are cited in the appendix to the testimony, but the heart of the testimony has to do with some colored charts. You can't see them from there, but in your black-and-white rendition, page 11 and on, there are some maps of the United States showing where the estimated job losses were from a series of employer mandates we looked at last year.

We are currently examining the job loss estimates for the administration plan and for 5 or 6 of the other plans, Cooper, et cetera. We won't be finished with that probably until sometime at the end of March, but I thought what I would do today, since we had studied employer mandates pretty thoroughly as well as individual mandates, is that I would take you through some of the conclusions about both job losses and other kinds of effects that are mostly likely to happen to employees and employers under the range of plans that are before us, all the way from employer mandates to individual mandates, as well as some more voluntary plans.

I am testifying here today as a private citizen. I am chairman of the board of CONSAD. I am an adjunct professor at schools in Pittsburgh, Carnegie-Mellon and University of Pittsburgh.

There has been a lot of complaint, I guess, about the wide range of job loss estimates under the plans. You have the Council of Economic Advisers, et cetera. The range of estimates is wide. At the lowest level, it is 400,000 jobs lost. Now, again, I am talking about other plans, other than the actual ones that specifically are here today because, as far as I know, I don't think anybody yet has really focussed on the current plans, but we are all doing it, obviously.

Anyway, the lowest level is something like 400,000, and the highest level is 3 million. Somebody might say, well, that is not really much of a difference out of 120 million workers, but if you are one of the extra ones above 400,000, it is very, very important.

The contribution of putting this on a map, showing, if you will, the kind of density of where these losses take place, showing the industries they are in, showing the size companies they are in, showing the hourly wages of employees in the firms that are going to suffer these either job losses—and by the way, there are job gains, too. So let me talk about that in a minute, but let's just focus on losses for a minute—also, by the employment status of the employees.

Basically, in the way we do our work, we separate out the entire country and all firms in up to 23,000 categories, (actually, many less, given the degree to which data is available), if you will, by their sector, by where they are, by their asset size, and we then characterize these firms as being able to withstand or not (that is, their vulnerability) the certain kinds of changes that each of these statutes, each of these policies are bringing to the table.

There is no economist that I know of that says that in the long run that the premium changes will not ultimately be a disbenefit

to the worker, in terms of either other compensation, education, or job losses. What our focus is, is also on the short run, what actually happens during the next 4 or 5 years.

The other day in the CBO testimony, I think that Mr. Reischauer said that he was mostly interested in the long run. It isn't that we are all dead in the long run, but I think that we have to be interested in both short- and long-term. You may have to be interested in what happens the first couple of years and the next couple, and, of course, anybody like myself that is in business and anybody like you that is in your business, those are important. Getting there from here is what our focus has been because that is where the gap is. The gap in estimating job effects have been mostly in these long term. It will happen some day when we get there. Our purpose is trying to fill that gap with numbers that make sense, that are credible.

There is another thing that when we published——

Mr. McDERMOTT. May I ask one question?

Mr. STEGER. Of course.

Mr. McDERMOTT. I am looking at your chart. What is S. 1227?

Mr. STEGER. OK. These are all the acts from last year.

Mr. McDERMOTT. Oh, from last year.

Mr. STEGER. Exactly.

Mr. McDERMOTT. All right. Not bills introduced in this Congress.

Mr. STEGER. No, but by next month, by the way, if you ask me back, we will be happy to give you the latest results.

Mr. McDERMOTT. All right.

Mr. STEGER. On page 9, for example, the Cooper bill last year was 1992, HealthAmerica, et cetera, but there were a lot of bills to learn from, and I am sure we have learned, for example, that rather than having 100-percent mandate, we have an 80/20 mandate. Rather than not have any subsidy for small business, we have small business subsidy. So that, the thing we have with the current bills are a lot of added complexities, if you will, versus those earlier bills.

Our computer models take about 4 or 5 months to complete, and I think that the way that we are running them now, we are running the base level. We are running the President's plan as it would work. Then we are going to depart from it because it might not work exactly as if planned. It might have a 10-percent cost overage or a 3-percent overage and what have you, and we will do that with every one of the proposals that are now on the table that are sensible proposals.

In addition to job losses, we are also focused on one other aspect. We are focused on what happens to the worker. He may keep or lose his job. He gets his health benefit, and his health benefit package could possibly change if he had one before. His family is a different status under most of these proposals than he has today. So we are going to keep track of that.

His wages will be different. His hours will be different. His fringe benefits will be different. So, when we say that a worker is affected, we don't mean his job is lost necessarily. Something like 5 to 10 percent of those who are affected will lose their jobs.

On the gain side, another thing happens. Let's say that premiums are lower than they were before. What happens with the

extra money? Does the employer immediately pay that extra money out to his employees as sort of like a windfall? Well, we know that that isn't the way the world works. Does the employer run out and hire more people? Well, that is the interesting thing about job losses and job gains. Job losses is when a firm is strapped. It had 10 workers. I can now afford 9 if it is a very heavy, extra increase in cost.

On the up side, let's say that it now has an extra 10 percent of good things for the employer. He now has more money. (In those cases, the premiums are less.) Why doesn't he rush out and hire an extra worker? He doesn't do that unless there is an extra demand for his product, and the economist says that only happens when the economy is now revved up as a result of whatever this policy is.

At the current time, the estimates I have seen by the macro models, if you will, like DRI or CBO the other day, they mostly say there is going to be a decrease in gross national product or demand. So it is our estimate that if there are job increases, they will come later than the job losses, I think that is important in terms of thinking about what happens in the next several years versus the years that are further out.

I have covered the primary points of difference between our estimates and others. I think that the way that we go about estimating these job effects are very reasonable because they are like what a businessman and a worker thinks about when they are either joining a firm or a businessman in hiring workers.

These aren't complex models. When the time comes and you would like to see the results of our—well, let me just also say that the results last year showed that approximately a million job losses would occur in small firms, and something like 10 to 12 million other workers would be affected in the way that I present it. Do I think those will be different? I am sure they will be different. I will be very happy to present those when we are ready.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF WILBUR A. STEGER CONSAD RESEARCH CORPORATION

The bases of this testimony are several reports (cited in the attached Bibliography), prepared by my CONSAD colleagues and myself since the late 1980's, analyzing the prospective employment consequences of alternative approaches to health care reform. These studies have been prepared for and supported by Federal agencies, research foundations, corporations and trade associations, and CONSAD, itself. I am an Adjunct Professor of Public Policy at Carnegie Mellon University and of Public Health at the University of Pittsburgh. I am Chairman of the Board and President of CONSAD Research Corporation, headquartered in Pittsburgh, Pennsylvania, since 1963, and the author of dozens of economic impact studies for Federal agencies, the U.S. Congress, and private sector corporations and associations. I appear here today as a private citizen and the President of CONSAD, to discuss findings and approaches which, I believe, will help to inform the current course of study and assessment.

For a profession so replete with differing opinions, economists do pretty well at things they do agree about concerning the employment effects of health care plans (Klerman, 1992; CONSAD, 1990b, 1992a, 1992b, 1993a, 1993b; O'Neill and O'Neill, 1993; Employee Benefit Research Institute, 1987; Morrissey, 1991; Klerman and Goldman, 1993; Feldstein, 1993). For example, relative to an employer mandate which raises the health care costs of many firms, and lowers the costs of others:

1. For firms whose health care costs are increased, they can either absorb the costs in reduced profits, raise prices, reduce workers' wages, and/or reduce employment; analogously, for firms whose costs are reduced, job gains are possible if demand for their product increases.
2. In something approximating the middle to longer run, increased costs to firms -- particularly those costs tied directly to labor as are health care premiums -- will be passed on to workers in the form of lower real wages and/or conditions of employment (e.g., reduced hours, fewer jobs, etc.).
3. With employers backward-shifting the costs of an employer mandates to wages, the currently uninsured will pay for much of their (new) health care out of reduced terms and conditions of employment.

That is where the agreement stops, however. At this point, where potential changes in jobs and earnings are to be estimated, the relative importance and modus operandi of different factors take over. The Employment Effects of Health Care (KPMG, 1993) cites the following difficulties in the conventional economic doctrine about these employment effects:

The most difficult piece of the analysis is converting the potential change in wages into an effect on employment. The sensitivity of one variable to another is called "the elasticity." It is expressed as the percentage change in one variable, given a 1 percent increase in another. Previous studies provide some guidance, but are not available at the level of detail desired. For example, industry level elasticities would be desirable, but are not available. Thus, an economy-wide elasticity would have to be applied equally across industries. The number of workers expected to lose their jobs due to health care reform would then equal the population at risk multiplied by the estimated employment elasticity.

Given this framework, economists have estimated the job loss impacts from a "pure form" employer mandate at 600,000 (Klerman; U.S. Council of Economic Advisers); 400,000 to 1.5 million (CONSAD, 1993a, 1993b); almost 3 million (O'Neill and O'Neill); 710,000 (Joint Economic Committee); and 200,000 to 1.2 million (Employee Benefit Research Institute). Economists who estimate the net differences of job gainers and job losers (e.g., Custer of EBRI,

Gruber of MIT) may even, with rather unique assumptions, come up with net gains in jobs (though with many "gross" job losers).

No question: there is indeed a need for research and reliable data into the topics of labor flexibility and labor demand elasticity. However, much good thought and work has already been accomplished in this area that have produced results. My own research in this arena (since the late 70's) and that of my colleagues has built on the increasing national interest in estimating the prospective "jobs" consequences for public policy options, i.e., changes in both gross and net employment (gained and lost) and by characteristic and "quality" of job, industry, and geographical region, the timing and direction of these consequences, and other size and qualitative dimensions of a total "jobs" picture.

The purpose of the discussion (below) is to present an approach to the assessment of such prospective employment consequences -- the jobs impacts -- of health care policy and regulatory options, and to illustrate these, using recent studies. The presentation draws upon a set of analytic approaches that have been developed, tested, and applied by CONSAD to evaluate a variety of policy options relating to environmental economics (CONSAD, 1988, 1991, 1990a, 1990c), and, presently, to health care reform options (CONSAD, 1990b, 1992a, 1992b, 1993a, 1993b).

Methods and approaches -- In a way, these applications have given CONSAD a sense of the many choices -- and objectives -- facing an analyst when performing a jobs impact analysis, e.g.: Should the short-term, transitional jobs effects be given a particular emphasis? Are states or U.S. regions experiencing impacts of particular interest? Are jobs gained and lost the only interest, or are other job effects (e.g., prospective wage or hours changes) important, too? Should the age and condition of an industry's current equipment, the characteristics of the work force, and/or the employer-employee bargaining relationship play a role? Or an industry's domestic and globally competitive position? And, if so (in each instance), what methods of analysis -- data bases, models, validation criteria -- make the most sense for each given level of analytic resources?

The methodology used by CONSAD in each instance, as much an art as a science, eclectically selects from a menu of data bases and models -- none of which is proprietary (to CONSAD) -- seeking to achieve policy-relevant, economically-valid information yields about critical economic impact subjects, for given levels of resource commitment and data quality and availability.

Most economics-oriented policy analyses of the impacts of policy options emphasize longer-term consequences, describing the impacts in broad terms, such as changes in gross national product (GNP), changes in total employment nationwide (i.e., netting out job gainers and losers), and changes in the national unemployment rate. Input-output, econometric and computable general equilibrium (CGE) models dot the analytic landscape. Although CONSAD's analytic approaches also consider impacts on employment in the intermediate and longer terms, we have provided a unique perspective to the evaluation of jobs impacts by focusing as well on the short-term and transitional effects of policy options on employment, particularly in the specific industries and geographic areas where jobs are most likely to be affected by the options.

Not surprisingly, the most significant gap in our understanding of the demand elasticity for labor -- in the short and longer run -- are ways to operationalize the relevant microanalytic theory. Clearly, any unintended, indirect jobs effects that might result from a health care policy option would derive from the impacts on the economic status (in particular, the employment and real income) of individuals (employees, owners of capital, etc.) and the firms, themselves. Such impacts emanate directly from the production and employment decisions of individual establishments subject to the policy; in turn, these propagate indirectly throughout the economy in response to the modified supply and demand decisions of those establishments and their employees. Consequently, any assessment of the unintended,

indirect effects of incremental policy logically must begin with an evaluation of the direct impacts of the regulation on managerial and ownership decision-making in individual establishments.

The most limiting case is one in which the only decision option for the affected firm (following the promulgation of the policy/regulation) is the selection of the level of production, i.e., if everything else is fixed, as is a likely, realistic assumption, in the short-run. Applying analytic concepts from the microeconomic theory of production, it is easily demonstrated that the adoption of more costly health care, for firms experiencing this result, will unambiguously result in some decrease in employment. A portion of the workforce will be laid off or hours of current workers reduced if the establishment remains in operation, or all jobs will be terminated if the facility is closed. While this is a limiting case, it speaks to the need for investigating effects over different time periods, for differently situated firms.

As to the matter of time periods, we (typically) assess the employment consequences that are likely to occur during three distinct time periods:

- The immediate, short-term period during which industrial facilities generally are restricted to producing their outputs using their existing physical equipment and workers with "sticky wages": here, the ability of firms to adapt to increases in costs by adjusting their production methods is severely limited. With some policy options, the short-term cost increases -- for some firms -- will be small enough that impacts on employment will be negligible. For some firms, however, the incremental costs will evoke substantial adverse changes in the terms and conditions of employment. At the extreme, workers might lose their jobs in companies and facilities that cannot afford to pay the increased costs of doing business. More commonly, workers may find their jobs to be at increased risk of decreases in wages and benefits, increases in the frequency and duration of layoffs, and increases in the potential for job loss.
- The intermediate, transition period during which existing equipment and processes become obsolete and wages become more flexible in both directions: here, within individual facilities, there are windows of opportunity open for implementing cost-effective changes to production processes in response to increases in costs. The process changes that companies decide to implement will have impacts -- often quite profound impacts -- on employment. This is particularly true where the policy option affects a particular factor of production (e.g., labor). The magnitudes of the impacts and the extents to which they are favorable (or adverse) will depend upon the degrees to which the process changes that are instituted in individual facilities, first, reduce (or increase) costs and, second, increase (or decrease) the labor-intensity of production.
- The long-term period when all currently perceived, potential modifications to production processes will have been either implemented or rejected for use by each individual company and facility. Analyses, pertaining to the long-term period, therefore, will not describe circumstances that are predicted to actually occur, rather, they describe the employment consequences toward which the economy is currently expected to converge, given the specific policy option.

Employment consequences in all three time periods depend upon the susceptibility of each firm (or "representative firms") to adverse or favorable economic impacts as a result of the policy-related cost changes. Such economic impacts and employment consequences are, also, determined by the responsiveness of demand for the firm's output to increases or decreases in costs and prices. If, as is generally true, demand for the commodities or services produced by an industry sector exhibits some responsiveness to changes in costs of production and product prices, any policy option that increases (or decreases) costs

appreciably will result in decreases (or increases) in sales and production, and hence some amount of job loss (or gain). Price change consequences are both micro and macro in nature. CONSAD's macroeconomic efforts, here, have either utilized partial equilibrium approaches or macro modeling (e.g., REMI, DRI, WEFA).

As for the differences between firms in their reaction to health care reform cost options, we use the following dimensions to characterize such variation, e.g.:

- Industry category
- Employment size
- Assets
- Net income
- Census region
- Hourly wage of employees
- Employment status of employees
- Coverage/type of employee

Results of applying these approaches are discussed in the next section.

2.0 SOME ESTIMATION

We have not yet fully examined the Administration proposal or the other newer health care reform plans to date but are currently in the process of doing so. Our latest publications, however, can, nevertheless, inform this debate because they do cast light on the more extreme, unmitigated, non-subsidized, "pure" employer mandate strategies.

2.1 Job Impacts

The proposals examined in these earlier reports (CONSAD 1993a, 1993b) were the most recent plans put before the public prior to the Administration plan and newer House and Senate plans of late 1993 and 1994:

- H.R. 5936: The Managed Competition Act of 1992 (the House proposal)
- S. 1227: HealthAmerica: Affordable Health Care for All Americans Act (the Senate proposal)
- A California Health Care System for the 21st Century (the California proposal)
- The 21st Century American Health System, devised by the Jackson Hole Group (the Jackson Hole Group proposal)
- The Heritage Foundation Consumer Choice Health Plan (the Heritage Foundation proposal).

Each proposal, except the Heritage Foundation proposal, contains provisions that will require industry to expand its role in providing and paying for health care insurance for employees. If the resulting labor cost increases are large enough, employers will compensate by changing other components of their employees' compensation and benefits packages or their employment status. These (earlier) studies estimate the numbers of jobs that will, consequently, be affected, and the proportions of those jobs that will be placed at-risk, if each of the proposed employer mandate based health care systems are implemented. A job-at-risk is one where there is a significant, recurring, unavoidable increase in total costs. Job losses are, typically, small percentages of the total estimate of "jobs at-risk," per se.

The particular importance of job gains and losses (first, gross, then net) -- our focus, here -- derives from the fact that important health care reform proposals involve the mandating funding by employers of employee health care insurance coverage. Although a reform proposal may mandate payment for insurance for employees, an employer does retain the option of changing other terms or conditions of a worker's employment to reduce or eliminate the new financial burden resulting from the reform provisions.

Thus, there is potential for substantial jobs impacts, including job losses and jobs placed at-risk of losing other benefits, wages, hours worked, etc.

These earlier studies (CONSAD, 1993a, 1993b) reported the following conclusions regarding the employment impacts of these proposals on small businesses:

1. The quality of job terms of many millions of small businesses workers, depending on the proposal, are at risk of substantial deterioration during the first several years of the operation of these plans. By "quality," we include significant reductions in wages, hours worked, and benefits, in addition to substantially increased probability of job loss.
2. Small business job losses will be substantial unless there is substantial flexibility and choice in the employer-employee relationship. While the earlier studies did not focus on job losses, a conservative, lower-bound estimate yielded a range of 390,000 to 900,000 lost jobs for the three rigorous business mandated proposals (California, Senate, Jackson Hole) and negligible job losses for the House and Heritage proposals. An upper-bound estimate finds the range for the three rigorous mandates to lie between 650,000 and 1.5 million job losses. A best-estimate for the earlier employer mandate proposals exceeds one million jobs lost.
3. Small business job consequences will vary among states and business sizes. California and Texas will feel the largest effects of health care reform, in terms of total number of impacted jobs and the percentage of total employment that will be severely affected. As a general rule, the smaller the size of a business, the larger is the impact in any given state.
4. Alternatives to increased corporate mandates have substantially different jobs effects. Payment schemes different from business mandates -- such as a value-added tax, a personal income tax, sin taxes, et al. -- will have decidedly different effects on small business jobs. Since these payment schemes, essentially, are not taxes on labor (as are the business mandates), they are likely, by and large, to have a lesser impact on small business jobs.

The U.S./state-by-state map exhibits which follow portray the states with the highest degrees of risk of job/impact for each of three earlier plans (no longer on the table per se) tied most closely to the pure-form employer mandates.

2.2 Demographic Impacts

This section describes the demographic characteristics of individuals whose jobs are estimated to be severely impacted by reforms based on a substantially employer mandate.

The demographic groups estimated to comprise the most severely affected workers are described below. The percentage of jobs that are at-risk among all of the jobs held by a demographic group and the proportional distribution of all jobs at-risk among various demographic groups are presented in the following Figures. The percentage of jobs at-risk within a demographic group is the ratio of the number of jobs at-risk to the total number of employed workers in the group. The proportional distribution of jobs at-risk among a demographic group is the percentage of the total number of jobs at-risk that are held by members of each demographic group. The proportional distribution of jobs at-risk reflects the absolute number of affected workers. The percentage of jobs at-risk within a demographic group relates the total number of workers in the group that are highly impacted. The data characterizing the workers at-risk are depicted graphically in Figures 1 through 10. It is important to note that, to improve clarity, the vertical scale on some of these graphs does not extend to 100 percent. The numbers displayed in the graphs and discussed below relate to the intermediate scenario of employees' health care insurance costs for each proposal. The discussion focuses on the distribution of the impacts estimated for different demographic groups and not on the

Exhibit 1: **Jobs at-Risk by State for Small Businesses**
(<500 Employees), Resulting from the S.1227 Proposal

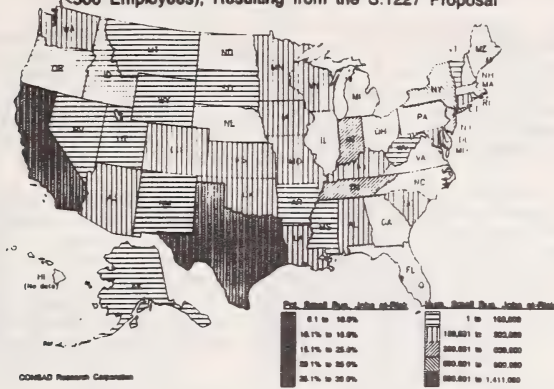


Exhibit 2: **Jobs at-Risk by State for Small Businesses**
(<500 Employees), Resulting from the California Proposal

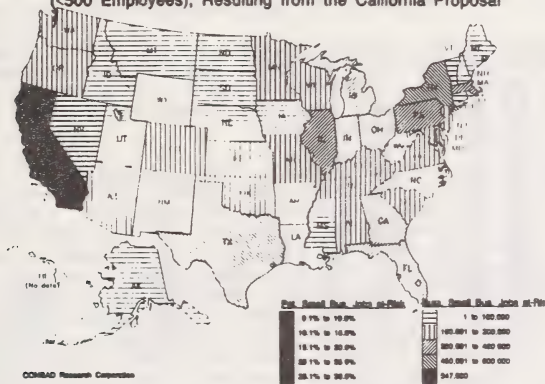
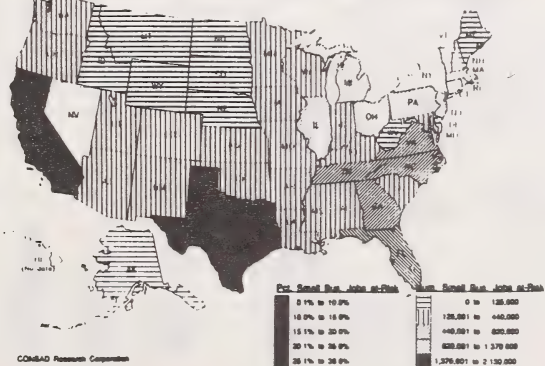


Exhibit 3: **Jobs at-Risk by State for Small Businesses**
(<500 Employees), Resulting from the Jackson Hole Proposal



numerical values of the estimated impacts. Each demographic characteristic is examined in a separate subsection.

Age Characteristics -- The results summarizing the age characteristics of the employees whose jobs are at-risk are presented in Figures 1 and 2. Young workers comprise the most highly impacted age group. The largest number of severely impacted workers are between 19 and 24 years of age, followed by workers who are between 25 and 34 years old. The least affected workers in absolute terms are those who are 65 years of age and older.

In relative terms, the workers who are 18 years of age and younger experience the highest impact. The oldest age group is the next most impacted: although the group of workers 65 years of age and older is small compared to other age groups of workers, the results show that a large percentage of employees in this age group, up to 45 percent for the more costly employer mandate proposals, will be potentially at-risk. This large impact is due, primarily, to the small average salary of employees who are 65 years old or older.

Gender Characteristics -- The results summarizing the gender characteristics of the workers whose jobs are at-risk are depicted in Figures 3 and 4. In both relative and absolute terms, female workers comprise the more highly impacted gender. The impact on female workers for the three employer mandates ranges from 17.8 percent of all female workers being at risk for the California proposal to 40.9 percent for the Jackson Hole Group proposal.

Race/Ethnicity Characteristics -- The results summarizing the race/ethnicity characteristics of the employees whose jobs are at-risk are portrayed in Figures 5 and 6. In absolute terms, whites comprise the most highly impacted group; in relative terms, blacks and hispanics are most affected.

Wage and Income Level Characteristics -- The results summarizing the individual wage level characteristics of the employees whose jobs are at-risk are depicted in Figures 7 and 8, and the results describing those workers in terms of their total family income levels are displayed in Figures 9 and 10. The findings relating to total individual annual income indicate that low wage/income workers will experience the greatest adverse effects from the proposals because their health care insurance costs will be large compared to their incomes. The interesting finding revealed in Figures 9 and 10 is that, for the Jackson Hole Group proposal, the impacts are not concentrated as heavily on those with very low incomes as are the impacts for the other proposals. In the Jackson Hole Group proposal, the number of workers with jobs at-risk is equally divided among all three cohorts of workers who earn less than \$20,000 annually. In the three other proposals, the impacts decrease as income increases.

An interesting feature of the results relating to total annual family income is that a considerable number of jobs at-risk are held by workers whose family incomes are greater than \$40,000. Indeed, for all employer mandates, the largest proportion of jobs at-risk are held by workers with family incomes above \$40,000. The second highest percentage of jobs at-risk are held by individuals with annual family incomes between \$10,000 and \$20,000, and the third highest percentage by individuals with annual family incomes between \$30,000 and \$40,000.

Exhibit 1 presents the bottom-line results of these demographic analyses.

Figure 1. Jobs at Risk, As a Percentage of Total Age Group Population

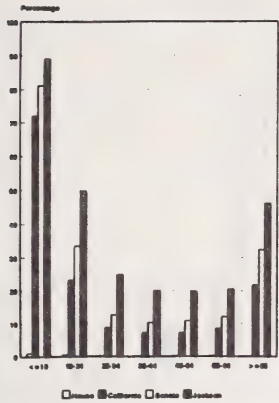


Figure 2. Proportional Distribution of Jobs at Risk by Age

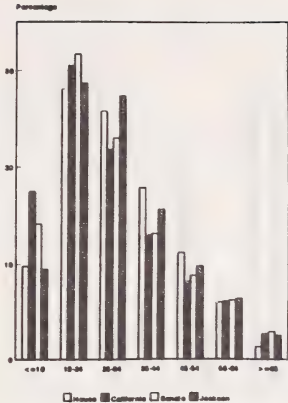


Figure 3. Jobs at Risk, As a Percentage of Total Gender Group Population

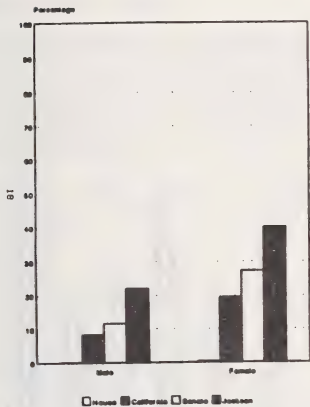


Figure 4. Proportional Distribution of Jobs at Risk by Gender

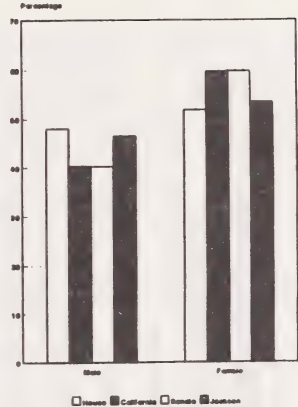


Figure 5. Jobs at Risk, As a Percentage of Total Race/Ethnicity Group Population

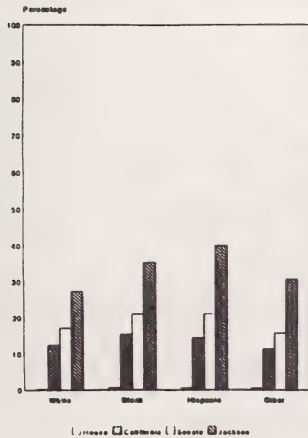


Figure 6. Proportional Distribution of Jobs at Risk by Race/Ethnicity

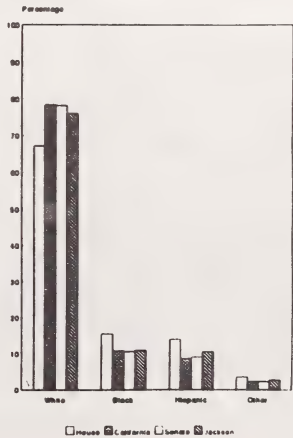


Figure 7: Jobs at-Risk As a Percentage of Total Population by Annual Wage Level

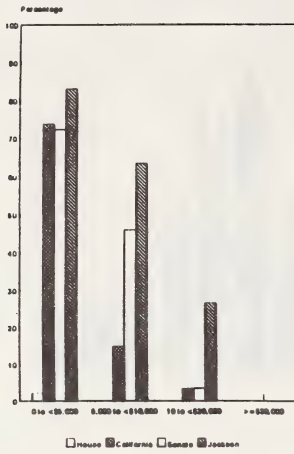


Figure 8: Proportional Distribution of Jobs at-Risk by Annual Wage Level

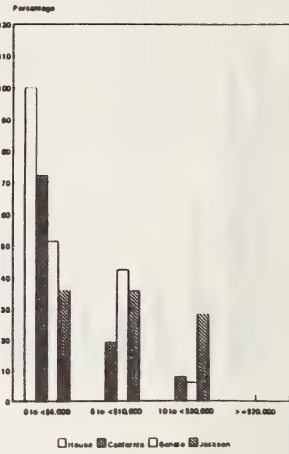


Figure 9: Jobs at-Risk As a Percentage of Total Population by Total Annual Family Income

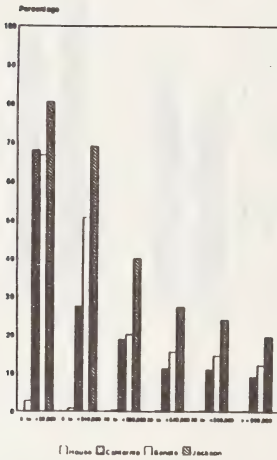


Figure 10: Proportional Distribution of Jobs at-Risk by Total Annual Family Income

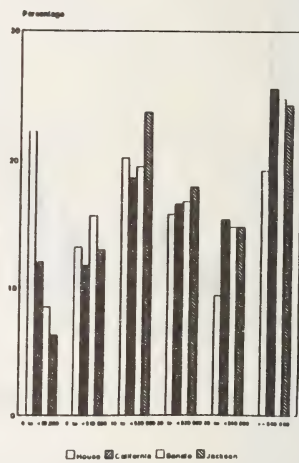


Exhibit 1: Demographic Results

- Young and Old Workers: Greatest Impact
- Female Workers: Greatest Impact
- White workers: Largest Absolute Impact; black and Hispanic Workers: Largest Relative Impact
- Low Individual Wages: Greatest Impact
- High Family Incomes: Greatest Impact

3.0 CURRENT ONGOING STUDIES

Our current efforts are focused on the Administration's proposal, Cooper (H.R. 3222), Chafee (S. 1770), Michel (H.R. 3080), and Nickles/Stearns. Exhibit 2 describes the approach -- more sophisticated and realistic than our earlier health care reform economic studies -- based on CONSAD's approach to short- to longer-term jobs estimation forecasting (CONSAD, 1993c).

Estimated changes in costs to the employer will, again, be the catalyst, particularly for the short-term, transitional impacts. The following are factors which are being considered as conditioning the firm's reaction (initial to later) to changes in costs (either reduced or increased):

- The firm's financial wherewithal (net income, liquidity)
- The competitiveness of the firm's product market, both domestically and internationally
- The importance of labor costs to total costs
- The difficulty and time period for substituting other than labor factors and their availability.

Exhibit 3 illustrates our logic process for the consideration of these factors.

4.0 CONCLUDING REMARKS

Health care reform proposals, in particular those proposals that require employers to provide health insurance coverage for their full- and part-time employees may have unintended and sometimes perverse consequences on the job-creation capacity of small- to medium-size business. In these instances where labor costs to businesses increase due to mandated health care coverage:

- Employers may need to reduce the wages and benefits of numerous workers, lay off others, and possibly cease operation.
- The ability of employers to adapt health benefits to the needs of their employees and enterprises may be reduced or totally eliminated.
- Existing businesses may be constrained from expanding and creating new jobs.
- New businesses may be inhibited from opening their doors.

Similarly, analogous impacts attend firms whose labor costs are reduced -- though these efforts are not necessarily parallel and in no ways "cancel out" the adverse effects.

The effect of health care reform on job gains and losses is, clearly, only one concern relevant to the health care debate. Other important economic and non-economic issues have not been directly considered, e.g., the ease of implementation of a new system; the number of additional workers and families who will receive health care insurance coverage; possible changes in total national health care expenditure; and changes in the health care status of all Americans. The particular importance of the job-impact issue derives from the fact that nearly all health care reform proposals involve consideration of either individual- or employer-funding (or mixed systems) of employee health care insurance. As a result, a health care reform proposal may, paradoxically, adversely affect the employment conditions of the particular groups of workers that it is intended to help through enhanced health care insurance coverage. Therefore, the potential effects on jobs must be carefully analyzed before the overall effect of a health care proposal can be evaluated in full: this is the contribution we are hoping to make.

Exhibit 2:
CONRAD Model for Estimating Economic Impacts of Health Care Reform Proposals

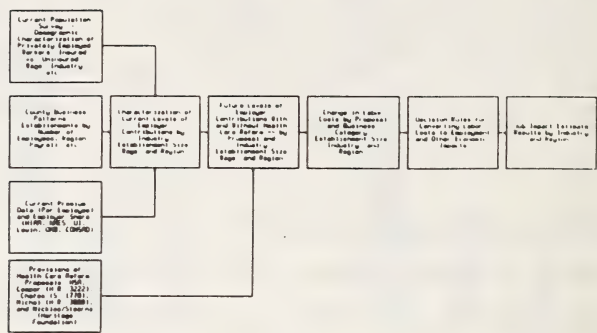
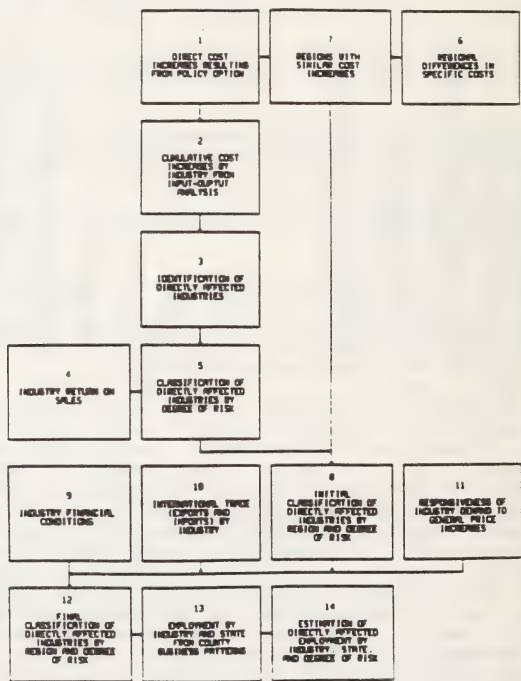


Exhibit 3: Approach for Estimating Employment Directly
Affected by a Policy Option During the
Short Term



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Mr. McDERMOTT. Thank you.
Mr. Lott.

STATEMENT OF JOHN R. LOTT, JR., CARL D. COVITZ TERM ASSISTANT PROFESSOR, THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA

Mr. LOTT. Thank you very much. It is, indeed, an honor to be here today.

I would like to comment on two things.

Mr. McDERMOTT. Excuse me.

Mr. LOTT. Yes, sir.

Mr. McDERMOTT. Let me stipulate everybody is a doctor, I think, except Mr. Schaeffer.

Mr. SCHAEFFER. No, I am not a physician.

Ms. McCAUGHEY. I am not a medical doctor either.

Mr. LOTT. I am usually not called "doctor."

Mr. McDERMOTT. OK. Mr. Lott.

Mr. LOTT. Thank you very much.

There are two things I would like to comment on. The first is the spectrum of price controls in President Clinton's health care proposal, and the second is what problems do exist with the current health care system, and I believe that those are exaggerated. They can be traced to previous Government regulations. The pattern seems to be that initial Government regulations generate problems and calls for eventually even more Government regulations.

With regard to the first point, on January 13 of this year, 565 Ph.D. economists from across the political spectrum, almost all of them academic economists, sent an open letter to President Clinton warning about the dangers of price controls in his health care plan. I am unaware of anywhere near this number of academic economists signing such a letter during at least the last few decades. Some of the economists had even signed the 1992 Clinton campaign letter endorsing some of his economic proposals.

Because I was disappointed with Dr. Reischauer's comments on Tuesday with regard to whether there were really price control aspects in the bill, I would like to take just a moment to read to you the letter that was sent to President Clinton on the 13th.

Dear President Clinton: Price controls produce shortages, black markets, and reduced quality. This has been the universal experience in the 4,000 years the governments have tried to artificially hold down prices using regulations.

You insist that your health care plan avoids price controls. We respectfully disagree. Your plan sets the fees charged by doctors and hospitals, caps annual spending on health care, limits insurance premiums, and imposes price limitations on new and existing drugs.

In countries that have imposed these types of regulations, patients face delays of months and years for surgery, government bureaucrats decide treatment options instead of doctors or patients, and innovations in medical techniques and pharmaceuticals are dramatically reduced. Here in America, the threat of price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries and the loss of life in the future.

In the 1970s, the government tried to regulate the price of a simple homogeneous product, gasoline. The result was a social and economic disaster. People were forced to waste hours waiting in long lines to purchase gasoline. Long waits for surgery and other medical care will have far more serious consequences.

Caps, fee schedules, and other government regulations may appear to reduce medical spending, but such gains are illusory. We will instead end up with lower quality medical care, reduced medical innovation, and expensive new bureaucracies to mon-

itor compliance. These controls will hurt people, and they will damage the economy. We urge you to remove price controls in any form from your health care plan.

I believe this letter is very straightforward and unambiguous. So I won't spend much more of my comments talking about price controls, but to me, if there is any one thing that economists agree on, even more than the benefits of trade such as in the recent NAFTA debate, it is that price controls produce shortages and that Government is particularly inept to try and set the right price for goods.

My second point, the great irony in this debate is how infrequently two facts are linked together. The first is people's concerns about the cost of health care. The second is that health care is already one of the most regulated areas of the economy.

The cost of Government regulations are huge and have been continually growing. You could almost present an endless list of regulations. You have a 12-year average delay between when drugs are developed and when they are finally approved by the FDA. Liability rules are extremely costly. For example, they can easily account for more than half the price differential between drugs in Canada and the United States. When you have licensing and other restrictions, it will make it difficult for groups, even like midwives, to provide services in certain circumstances.

On the other side of the debate, advocates who have been imposing national health care plans point to problems of "cost shifting" caused by uninsured individuals; that these individuals are burdening the system and shifting cost to those who are paying their own way. Yet, the cost shifting produced by uninsured individuals is trivial compared to the cost shifting created by the Federal Government.

Hospitals deliver \$9 to \$11 billion each year in unpaid medical care, helping the uninsured and even insured individuals whose insurance fails to reimburse the hospitals. Approximately in 1987, at least, another \$15 billion were doctors who were unpaid for their services. Even these numbers, though, exaggerate the burden of the uninsured because it fails to take into account that the uninsured aren't receiving the tax subsidies that other workers are receiving, the tax subsidies for buying insurance.

By contrast, if you look at the cost shifting done by the Federal Government, for instance, in the President's plan, he projects \$236 billion in savings through the Government simply lowering the fees it pays through government insurance plans to doctors and hospitals. The benefits remain the same, but we are simply cutting reimbursements. This is on top of "\$56 billion in savings" that got under the most recent budget agreement last year, and, of course, there were similar types of cuts under the Reagan and Bush administrations.

The additional \$26 billion in savings in the Clinton health care plan should be referred to what they really are, a massive tax increase on the health care industry. It seems strange that imposing a large tax is perceived as a solution to high prices.

Finally, Americans are overwhelmingly happy with the quality and access to their own health care. Polls show that they believe that the system is in trouble primarily because of lack of portability and the possibility that individuals could lose their own insurance because of illness.

Again, I believe both of these problems arise because of existing Government regulation. Let's take the case of lack of portability. This problem largely stems from tax deductibility of health insurance being tied to firms as opposed to it either being given directly to individuals or eliminating the deduction entirely. There is no reason why, other than inertia, for why this deductibility should be tied to an individual's job.

In conclusion, I would like to say that we should think of why we are in the situation to begin with. Why have these problems arisen? I think that will provide us with some perspective whether the solution is going to be even more greater Government regulation in the future. I think if we realize that it is Government regulation which produced a lot of the problems that people are worried about today, if not most, then I think it should give us some caution before we advocate even further government involvement.

Thank you.

[The prepared statement follows:]

Reforming Health-care

John R. Lott, Jr.*

1) Price Controls in President Clinton's Health-care Plan

On January 13th of this year, 565 Ph.D. economists from across the political spectrum (almost all them academic economists) sent an open letter to President Clinton warning about the dangers of price controls in his health-care plan. I am unaware of anywhere near this number of academic economists signing such a letter during at least the last few decades. Some of the economists had even signed the 1992 Clinton campaign letter endorsing some of his economic proposals. Because I believe that this letter is quite relevant to today's discussion of controlling the price of drugs, I would like to read the letter to you.

An Open Letter to President Clinton on Health Care Reform

Dear President Clinton:

Price controls produce shortages, black markets, and reduced quality. This has been the universal experience in the four thousand years that governments have tried to artificially hold prices down using regulations.

You insist that your health-care plan avoids price controls. We respectfully disagree. Your plan sets the fees charged by doctors and hospitals, caps annual spending on health-care, limits insurance premiums, and imposes price limitations on new and existing drugs.

In countries that have imposed these types of regulations, patients face delays of months and years for surgery, government bureaucrats decide treatment options instead of doctors or patients, and innovations in medical techniques and pharmaceuticals are dramatically reduced. Here in America, the threat of price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries and the loss of life in the future.

In the 1970s, government tried to regulate the price of a simple homogeneous product, gasoline. The result was a social and economic disaster. People were forced to waste hours waiting in lines to purchase gasoline. Long waits for surgery and other medical care will have far more serious consequences.

Caps, fee schedules, and other government regulations may appear to reduce medical spending, but such gains are illusory. We will instead end up with lower quality medical care, reduced medical innovation, and expensive new bureaucracies to monitor compliance. These controls will hurt people, and they will damage the economy. We urge you to remove price controls, in any form, from your health-care plan.

This letter is very straightforward and unambiguous. To me, if there is any one thing that economists agree on, it is that price controls produce shortages and that the government is particularly

* Lott is the Carl D. Covitz Term Assistant Professor at the Wharton School, University of Pennsylvania.

inept at determining what the correct price of a good should be. Anyone who sat in long lines at gas stations during the 1970's can remember how unsuccessful the government was at setting prices for even a relatively simple homogenous product like gasoline. After Reagan eliminated gas price controls in 1981, we never again experienced any more gasoline shortages.

Price controls cannot prevent real price increases, but can only change the form that they take. With gas, we paid through the time that we were stranded in lines. For medical care, patients still pay for higher medical care prices with their time by waiting for care — just ask people suffering delays for surgery in Canada or Britain.

For drugs, controls will reduce the number of new drugs, with the resulting loss of lives that those drugs would have saved. Inventing new drugs is costly with an expected cost averaging \$231 million. In addition to research and development costs, there is the twelve year average delay for new drugs endure in getting through the government approval process.

Before we can understand why drug companies set the prices that they do, we must understand why patents exist. Patents encourage innovation. Without patents, a competitor could produce the new drugs at a low price and prevent the drug's inventors from charging a high enough price to cover both production costs and recoup the large development costs. The temporary monopoly insures the incentives to develop new drugs. Reducing the prices that companies can charge reduces innovation just as surely as reducing the length of the patent life, but regulating individual prices is much more arbitrary.

It is politically tempting to force down the prices that drug companies can charge to make drugs more affordable. Yet, while the need to help the poor who are sick today is immediate, the long run consequences to forcing drug companies to pay for society's compassion takes the form of fewer new life-saving drugs tomorrow.

Let me take one example: There has for some years been an effort to force down the selling price of AZT, which delays the onslaught of AIDS. Even putting aside recent concerns over AZT's effectiveness, the question is whether those suffering from AIDS really benefit from such a measure. Surely, they will get AZT at a lower price, but what will happen to research for a cure? Depending on how restrictive the controls are, even companies which are most of the towards developing a cure will have to rethink any additional investments. Those with AIDS should hope that drug companies view inventing the cure as a financial bonanza and not as a prize whose profits will be regulated away.

One of Clinton's major themes is that drug prices are needlessly 32 percent higher in America than they are in Canada. While this figure is exaggerated, a difference does exist even if the correct numbers are used.¹ A drug company will sell an already developed drug in Canada as long as they can cover the drug's manufacturing costs. In some sense, Canadians are "free-riding" off Americans because the drugs were only developed in the first place because of the higher profits expected on American sales. Unfortunately, with price controls all over the world, there remain no large markets for us to free-ride on.

While price controls on oil and other products are usually short-lived as people see the havoc created by government intervention, the pernicious effects of drugs regulations are more obscure. With long lags in the approval process for drugs, it will be years before we notice the lack of new drugs.

Even when people eventually realize that controls are preventing new drugs from being developed, it will be very difficult to remove these controls. If controls are removed, there would be a long delay before new drugs start being produced again. It is unlikely that a future presidential candidate will be very successful if he goes before the voters and asks them to endure higher prices for many years before new drugs will again start appearing. Nor is it obvious that such a lifting of regulations will have the desired effect, since the drug companies would have to be convinced that new controls would not be imposed as soon as newly developed drugs hit the market.

In the last year year-and-a-half since then candidate Clinton surged in the June 1992 opinion polls, the sixteen largest drug companies have lost nearly \$100 billion in combined stock market value, and companies began perceiving price regulations as a real threat. As the expected returns to being in the pharmaceutical industry have plummeted, how many future lives have already been lost because the ideas for new drugs have been shelved?

In fact, a significant portion of the reduced growth in gross national product during the first half of 1993 of 1.3 percent after the robust growth during 1992 of 3.1 percent is attributable not only to the threat of higher taxes but more importantly to the retrenchment that occurred in the medical sector of our economy. When one seventh of our economy retrenches because of the threat of price controls and other regulations, it is not too surprising that it had visible effects on the nation's growth rate. When price

¹ Richard Manning finds that 50 percent of the drug price differential between Canada and the United States can be explained by differences in how the two countries treat product liability (see Richard Manning, "Products Liability and Drug Prices in Canada and the United States," Brigham Young University Working Paper, January 1994).

controls are threatened, particularly when rumors abound that quality controls which will prevent hospitals and other medical care providers from responding once controls are imposed — those affected by the controls immediately start reducing quality and output.

The price controls will also produce one other devastating result when they are combined with Clinton's planned reductions in reimbursement rates for Medicare and Medicaid. In the past, hospitals had to make up for the losses on government insured patients by charging their private patients more, but the problem now is that the proposed government price controls will prevent that from occurring. So what will happen? Hospitals will lose money and many will either go bankrupt or, as a last resort, the government will end up taking them over.

II) Is there a Crisis in Health-care?

When people are asked to comment on their own personal health-care, recent polls do not indicate a feeling of crisis. 83 percent of Americans rate the quality of their own health care as "excellent" or "good," and 73 percent tell pollsters that they are either "extremely happy" or "happy" with their access to health care. Yet, polls also show a similar percentages of people believe our health care system is in crisis when they are asked about the state of the system as a whole. Unfortunately, these feelings of crisis are being triggered by misleading claims over the number of Americans who go without health care and the waste that is said to exist in the system. Exaggerations by politicians of the chances that health care "won't be there for them next month or next year" only serve to fan those fears.

The oft repeated claim is that 35 to 37 million Americans are now without health insurance, with the implication that they are without health care. Yet, the Administration's own numbers about the uninsured indicate that almost 40 percent of these people find themselves in that position for less than two months. More importantly, even among the 8 million people are uninsured for at least a year, being without insurance does not imply going without health care. Despite the uninsured being relatively young (40 percent are between 18 and 29 years of age) and in relatively good health, they are 75 percent as likely to visit a physician and almost 50 percent as likely to obtain hospitalization as those with private health insurance. Hospitals deliver \$9 billion to \$11 billion each year in unpaid medical care helping the

uninsured and insured individuals who insurance fails to reimburse the hospitals, and a 1987 survey of doctors found unpaid care averaged \$28,900 per physician that year — totaling another \$15 billion.

Not only do these numbers indicate that being uninsured does not imply that one is without care, but they also shed light on a related concern — the complaint that the uninsured are burdening the health-care system and shifting large costs to those who are paying their own way. While \$26 billion per year is significant, it pales in comparison to the cost shifting produced by the federal government. These numbers even overstate the burden imposed by the uninsured since they are not receiving the tax subsidies provided to those who buy insurance.

By contrast, Clinton's medical plan projects \$236 billion in "savings" though the government simply by lowering the fees it pays through government insurance plans to the doctors and hospitals. These fees already fail to cover the costs of providing Medicare and Medicaid patients with mandated services. Clinton should call this \$236 billion "savings" what they really are — a massive tax increase on the health care industry. This is on top of the similar \$56 billion in Medicare and Medicaid "savings" just enacted in last year's federal budget battle. It seems strange that imposing a large tax is perceived to be the solution to high prices.

III) Portability of Insurance and the Perceived Threat that People Can Lose Their Insurance

Polls indicate that two important problems are perceived as existing in health-care. The first stems from people's inability to take their existing insurance plans with them when they change jobs. The second is the fear that people will lose their health insurance after a serious illness. While the severity of these two problems tends to be exaggerated (for example, only about 0.7 percent of the population is uninsurable), these problems exist in large part due to existing government regulation.

The problem of portability largely stems from the tax deductibility of health insurance being tied to firms as opposed to it either being given directly to individuals. Alternatively, the deduction could be eliminated entirely. There is no reason other than inertia for why this deductibility should be tied to an individual's job.

The problem of losing insurance could be solved by insurance companies offering long term insurance contracts. However, the main reason that they do not offer it is because of how courts and state regulators treated those types of insurance contracts in the past. The structure of these contracts

entailed people paying relatively high amounts during the initial periods of the insurance. However, healthy individuals who desired to leave the policy when more attractive alternatives came along sued over the high up front payments locking them into these contracts. Courts and state insurance regulators typically ruled that the insurance companies were required to rebate these initial high payments so that these healthy individuals could leave. Individuals in poor health however would have no desire to leave since the rates charged by other new policies would definitely be higher than the guaranteed rates they already had. Insurance companies offering long term policies thus quickly realized that they could easily be trapped into insuring a disproportionately large share of ill individuals.

IV) Conclusion

If Congress passes legislation containing price controls, we will all be paying for them long into the future. Controls on somethings such as drugs, because of the long lag times before their more pernicious effects are realized, will be particularly difficult to remove later. Possibly the most puzzling aspect of this whole debate, however, is the focus on more government regulation and central planning to solve existing problems. What is most surprising is that this is occurring after the failure of central planning in Eastern Europe and the former Soviet Union and after so many countries like Sweden have turned away from their own versions of the welfare state.

Mr. McDERMOTT. Thank you.
Mr. Helms.

STATEMENT OF ROBERT B. HELMS, PH.D., RESIDENT SCHOLAR AND DIRECTOR OF HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH

Mr. HELMS. I wish to present some principles of health care reform that would achieve what economists have identified as "efficient" health care reform. I think there is substantial agreement on all sides that we would like to see a health care system that would be cost effective, innovative, and would increase the quality of care.

There is no getting around the fact that expanding insurance coverage will increase the demand for care. It will increase the demand both by those who are presently uninsured and by those who are presently insured, especially those who would get increased benefits.

We know from a large body of economic research that people with insurance try to use the system more extensively. This will put upward pressure on both prices and expenditures.

Economists say that you can keep prices under control with increased demand if you increase supply. But that really is not part of the health care debate because it takes a long time to train new people and add facilities. Expanding supply reduces prices but increases total expenditures (assuming elastic demand).

What people want to get out of health care reform is the reduction of unit cost, that is, shifting the supply curve down through improvements in efficiency.

In my view, there is a lot of wishful thinking going on about reducing unit costs. Neither regulation nor so-called competition will reduce unit costs without a lot of help from consumers on the demand side.

There are basically two ways to get consumers to change their behavior. Medical savings accounts might help in some sense, but in my view they are far inferior to facing up to the fact that we have a tax system which greatly distorts individual incentives.

I know this is a tough political issue for all Members of Congress, but as an economist I think it is my duty, to remind you that you can not get efficient reform unless you do something about this issue. Changing the present tax treatment of health insurance is very important to getting people to change their behavior to seek out more cost-effective care. Any cost-containment strategy is doomed if most consumers continue to try to increase their utilization of health care services.

One reason I am particularly disappointed with the Clinton approach is that it effectively ignores the demand side of the equation. The Clinton task force started with the Jackson Hole proposal but then walked away from what Alain Enthoven considers to be an essential part of the proposal—a change in the tax treatment of health insurance necessary to get the consumer behavior on the demand side to make his system work.

In my view, the Clinton proposal will not give you effective competition because of the way it has set up the alliances and the bidding process. We are more apt to get numerous regional cartels

where each health plan is in a cozy little relationship that is regulated by the health alliance.

The other thing that I would urge you to be leery about is the notion that we know exactly how the process of competition should work over time. That is very difficult for anyone to predict. We probably has linders on about how this competitive process may play out. In essence, if we get the incentives right on the demand side, there will be lots of room for providers to think up new ways to satisfy consumers and to compete on the basis of quality, convenience, and service. This is not the kind of competition you will get in a regulatory system, as John Lott has just indicated.

I am happy to say I was one of the economists that signed that statement.

In addition, individual incentives matter in all health care markets, which is my way of saying it is a mistake to leave out Medicare, Medicaid, the veterans programs, the Indian Health Service, and any other health program. If we could get behavior changes among all these consumers, it would make the whole market more efficient.

Let me remind you that the Medicare health insurance trustees have been saying for several years that the Medicare (HI) trust fund is in serious trouble, especially in the next century when the baby boomers begin to become eligible for Medicare. The Congress has got to face up to this problem at some point, so I believe you do not serve the American people well if you leave this issue out of the consent debate.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Testimony of
Robert B. Helms
February 10, 1994¹

It is common to read in press accounts of the health reform debate that the difficult topic of health care reform is not understood by most Americans or even by members of Congress. While some aspects of health care reform are indeed difficult to understand, I believe the basic economic issues are straightforward and can provide a useful guide to achieving health reform that will improve the efficiency of our health care system.

First, if through mandates or expansions of government programs we provide health insurance coverage to additional individuals, we know that this will increase the demand to use our health care system. Both people with serious medical conditions and people who are relatively healthy will attempt to obtain care from providers simply because they will have an insurance plan that covers these services. The effect of an increase in demand will put upward pressure on both prices and total expenditures in the health care sector.

The rise in prices, but not necessarily in total expenditures, could be prevented if there was a large enough increase in the supply of medical personnel and facilities. But it typically takes years to add substantially to the supply of health care providers so that most policy discussions do not seriously consider the option of additional supply. Instead, policy proposals typically focus on ways to get each consumer of health care services to reduce their personal demand or to induce providers to improve the efficiency of their delivery (i.e., increasing supply through reductions in unit costs rather than increasing capacity).

However, a third approach, but in my view totally misguided, is always inserted into such policy debates: a proposal to regulate prices.² This approach ignores the fundamental economic behavior of both consumers and providers (supply and demand) and assumes that prices and total expenditures can be controlled by direct government controls. "Price regulation can go by numerous names (eg. wage and price controls, incomes policies, global budgets, or even private insurance premium caps), but whatever it is called it always involves the notion of directly reducing unit prices below the level that would have been established in a competitive market.

Such controls do cause both providers and consumers to change their behavior to try to avoid the effects of non-price rationing that result from controls. These types of behavior changes are wasteful and inefficient when compared to the behavior changes that would be brought about by changing market forces. For example, if consumers had stronger incentives to reduce their personal demand for medical care, they would put more effort into identifying and using those providers who can deliver more cost-effective and quality care. Such providers would be rewarded relative to those providers not providing the quality and convenience demanded by consumers. In a regulatory environment with effective price controls, providers have incentives to ration the care they are willing to deliver. This rationing can take several forms depending on the personal preferences of the provider to serve certain people but not others. It is naive to believe that the regulatory authority can prevent all the types of personal discrimination that would result. Under controls the

¹The views expressed in this testimony are my own and do not necessarily represent the views of the American Enterprise Institute.

²On the history of wage and price controls, see Robert L. Schoettinger and Eamon F. Butler, *Forty Centuries of Wage and Price Controls* (Washington, DC: Heritage Foundation, 1979). For an excellent review of the economics of government regulation, see Paul L. Joskow and Roger C. Noll, "Regulation in Theory and Practice: An Overview," in Gary Fromm, ed., *Studies in Public Regulation* (Cambridge, MA: The MIT Press, 1981), pp. 1-65. For an assessment of controls in more modern times, see Stuart M. Butler, "The Fatal Attraction of Price Controls," in Robert B. Helms (ed), *Health Policy Reform: Competition and Controls* (Washington, D.C.: The AEI Press, 1993), pp. 3-21.

providers do not have incentives to meet the unmet needs of all consumers that have incentives to try to obtain medical care. The result is a set of incentives that will lead to a decrease in the quality and convenience of medical services.

While the lessons of economics may be straightforward, the Congress faces the practical question of determining what policy changes will bring about consumer and provider individual incentives that will promote efficient health market reform. I believe the very large body of economic and policy analysis conducted over the last 20 years provides some guidance in this search for efficient policies.

My principal criticism of the Clinton administration's Health Security Act (HSA) is that it walks away from policies designed to change consumer behavior and concentrates almost entirely on changing the performance of providers. By expanding benefits both to the uninsured and to many of those presently insured, the proposal obviously increases the demand for care. Even though the administration started with the Jackson Hole Proposal as the basis of their plan, they made some important changes that substantially change the incentives of both providers and consumers from that envisioned by the architects of managed competition.³ On the demand side, they essentially abandoned the change in tax policy that would have eliminated the present exclusion of employer-provided health insurance, a policy change that I believe is a necessary condition for changing consumer behavior. Without a change of behavior on the demand side, the Clinton proposal puts all of its eggs in the basket of supply-side changes. While the administration has proposed to use caps on health plan premiums only as a backup in case their competitive changes do not sufficiently control costs, they have also made two important changes in the Jackson Hole Proposal that I believe takes the linchpin out of the Jackson Hole competitive machine.

First, in the bidding process to determine which competing health plans will be offered in each area, they changed the lowest-cost bidder standard to a weighted average cost standard. The weighted average of the successful bids determines the per capita amount that is the standard for computing each employer's mandated payment (80 percent unless the firm qualifies for one of the small firm, low wage, or expensive benefit exceptions). While a competing health plan may have some incentive to be a low-cost plan to attract employees (who can avoid paying some or all of their 20 percent share of the average premium), this incentive would be much weaker than under the low-cost standard.

Second, by giving the health alliance exclusive power to qualify (and disqualify) plans, administer the bidding and negotiating process, and collect and disperse all money flows between employers, individuals, and health plans, the HSA substantially changes the incentives of health plans to aggressively compete on the basis of both price and quality, a primary objective of the Jackson Hole Proposal. In fact, if looked at through the prism of the economics of cartels, the most likely outcome of the HSA competitive process will be a series of regional cartels managed by the regional health alliance. Aggressive competition to reduce prices or expand quality or service would be viewed as disruptive to the best interests of the health alliance officials and the other health plans. Instead of a competitive process that would eliminate wasteful medical care and drive down costs as envisioned by the Jackson Hole group, a series of health cartels would have little effect on total health expenditures but would substantially stifle innovative changes in health care delivery and financing.

The following is a discussion of several specific policies that I think should be considered by the Congress as it seeks to improve the efficiency of our health care system. It starts with a discussion of the role of tax policy, a difficult political issue but one that I think is essential for effective reform.

³For a description of the proposal, see Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheredge, "The Jackson Hole Initiatives for a Twenty-first Century American Health Care System," *Health Economics*, vol. 1 (1992), pp. 149-168, and Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, vol. 12, suppl. (1993), pp. 24-48.

The Role of Tax Policy

Tax policy has played an important role in creating the distorted set of incentives we now have. There is no way of avoiding the fact that the present treatment of employer-provided health insurance benefits must be changed if we want to avoid government regulation and establish a health care system that improves economic efficiency.

Economists and other health policy analysts have been writing about the distorting effects of federal tax policies for over 20 years.⁴ Beginning in World War II employers started to provide health insurance as a way to compete for scarce labor under wage controls. Health insurance has never been treated as taxable income by the IRS. While this 50 year old policy has been credited with preventing the nationalization of health insurance that we have seen in other countries, it has also been identified as a major cause of "overinsurance" and "too much insurance of the wrong kind." By distorting the choice between taxable wages and non-taxable health insurance, this tax treatment of health insurance has caused the absolute growth of insurance, the gradual reduction of cost sharing, and the extension of coverage to types of medical care such as dental and vision care that are rarely associated with low-probability and expensive medical events. These large and long-term subsidies have gradually changed health insurance from the traditional concept of insurance (coverage of large and unexpected events) to a form of medical prepayment.

Because this tax preference is limited to employer-provided insurance, it has contributed to "the third-party payment problem" where each individual assumes that someone else will pay for whatever medical care they consume. Under such a system, there is little reward for choosing a hospital, physician, or medical procedure or product that costs a little less.⁵ This has led numerous analysts to identify the tax treatment of health insurance as a major cause of the rapid rate of growth of both health care prices and expenditures.

The distorting effects of the present tax treatment of health insurance have led almost all academic-based health reform proposals (except the single-payer proposals) to propose to

⁴To sample some of this literature, see Martin S. Feldstein, "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy*, vol. 81 (March 1973), pp. 251-80; Ronald J. Vogel, "The Tax Treatment of Health Insurance Premiums as a Cause of Overinsurance," in Mark V. Pauly, ed., *National Health Insurance, What Now? What Later? What Never?* (Washington, D.C.: American Enterprise Institute, 1980), pp. 220-249; Jack A. Meyer, "Health Care Competition: Are Tax Incentives Enough?" in Mancur Olson, ed., *A New Approach to the Economics of Health Care* (Washington, D.C.: American Enterprise Institute, 1981), pp. 424-449; Pauly, Danzon, Feldstein, and Hoff, *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992); Eugene Steuerle, "The Search for Adaptable Health Policy Through Financed-Based Reform" in Robert B. Helms, *American Health Policy: Critical Issues for Reform* (Washington, D.C.: AEI Press, 1993), pp. 334-361; Alain C. Enthoven, "Why Managed Care Has Failed to Contain Health Costs," *Health Affairs*, Vol. 12, No. 3 (Fall 1993), pp. 36-37.

⁵The distorting effects of federal tax policy have been exacerbated by the growing importance of state income taxes where employer-provided health insurance is not considered part of state taxable income. But since state income taxes rarely add more than 5 to 7 percentage points to federal marginal tax rates of 30 to 40 percent, the state effect remains relatively small when compared to the effect of federal tax policy. For recent estimates of the loss of tax revenue from different sources, see Stuart Butler *A Policy Maker's Guide to the Health Care Crisis, Part II* (Washington, DC: The Heritage Foundation, March 5, 1992) Table 12, p. 20.

These distorting effects are further exacerbated by the open-ended nature of Medicare and Medicaid which also gives little incentive for individuals to be cost-effective medical consumers. See Steuerle, "The Search for Adaptable Health Policy Through Financed-Based Reform" in Robert B. Helms, *American Health Policy: Critical Issues for Reform* (Washington, D.C.: AEI Press, 1993), pp. 334-361.

either eliminate or limit the amount of the tax exclusion for health insurance.⁶ In my view, making such a change in tax policy is almost a necessary condition for achieving economically efficient reform. It is the most effective policy change under consideration that would affect the demand side of the market by giving individuals a greater incentive to be cost-effective purchasers of health care. This change in consumer behavior is essential to make competitive markets function as they should. If consumers demanded more cost effective care (which may include even higher quality and service), then providers of all types would have no choice but to change their practices and compete more on the basis of price and quality.

Let me also say that calling for a change in the open-ended nature of the tax treatment of employer-provided health insurance is not an argument for increasing federal tax revenues or in any way "increasing the taxes on businesses or labor." This is an argument about eliminating the distorting effects of these tax policies, not an argument about increasing the level of taxes. If the Congress did not want to divert the expected increase in revenue to pay for expanded coverage of the uninsured (as proposed in several health reform proposals), it could lower both business and personal tax rates to assure no increase in federal revenues.⁷

Letting the Market Rule the Process of Competition

As this hearing illustrates, the focus of the national debate about health reform is shifting from the administration's proposal to alternative health reform proposals, most of which are based on some version of the concept of managed competition. While Alain Enthoven and the Jackson Hole group should get substantial credit for bringing an important set of ideas to the health policy debate, there is one aspect of their approach which I think the Congress should resist. The Jackson Hole Proposal goes to great lengths to specify the basic benefit package the competing health plans must offer and the organization and structure of these plans. This may have some advantages to assist consumers to make comparisons among plans, but it also has some disadvantages. The process of competition in all markets can take many forms including competition based on the design and quality of the product or service. In health care markets characterized by more intensive competition than we have experienced in the last few years, this competition could take forms which might be impossible for us to foresee at this time. If we create the correct incentives on the demand side and resist the temptation to be too restrictive on how providers might respond to the desires of consumers, we do not lock ourselves into the equivalent of horse-and- buggy technology, turn-of-the-century retailing, or present-day health insurance policies. Neither policy wonks or the wisest members of Congress should assume that we can predict the most efficient form of health insurance or health care delivery in the coming decades. The principal advantage of competitive markets is that they are far more efficient in adapting to changing consumer preferences and technologies than any legislative or regulatory body.

⁶A tax exclusion cap which limits the amount of employer-provided health insurance an individual can exclude from taxable income should not be confused with a tax deduction cap (as proposed in the Managed Competition Act of 1993, introduced by Reps. Jim Cooper and Fred Grandy) which limits the amount a business firm can deduct for the expense of providing health insurance to employees. Among other effects, these two types of tax caps could have substantially different effects on labor-management relations. It is my opinion that the former could create a mutual interest among labor and management in effective cost containment while the latter would tend to drive a wedge between the interests of labor and management.

⁷While this could be done in a revenue-neutral way, it would not be possible or desirable to avoid the differential effects on individual businesses and individuals. While the net effect on any one business or individual would depend on their level of benefits and marginal tax rate, it is likely that such a policy would create incentives for firms and individuals with extensive health insurance benefits to cut back and for firms and individuals with little or no benefits to obtain more coverage. While this would not assure universal coverage, it would increase the level of health insurance coverage without the net job losses that are likely to result from the Clinton Plan's employer mandates and small firm subsidies.

Present Government Health Programs Should Not be Exempt from Reform

Most health reform proposals attempt some reform for the problem-ridden Medicaid program, but few include any real revisions that would change the demand-side behavior for those eligible for coverage under Medicare, the VA programs, the Indian Health Service and the various military programs for civilians. The political wisdom seems to be that it is not worth expending political capital by proposing to include these programs. While there may be specific budget or program reasons to include these programs in the debate (especially the longer-term trust fund problems in Medicare), the primary reason they should not be left out is that together they make up a substantial fraction of the United States health care market. Even if we have efficient reform in private health markets, we cannot get the full benefit of reform if this substantial block of consumers still retains perverse incentives to overuse the system and not change their own personal behavior regarding their health care choices.

Mr. McDERMOTT. Thank you.

Dr. McCaughey? I called you McCaughey before. That is the Gaelic way.

STATEMENT OF ELIZABETH P. MCCAUGHEY, PH.D., JOHN M. OLIN FELLOW, MANHATTAN INSTITUTE, NEW YORK, N.Y.

Ms. MCCAUGHEY. That is just fine with me.

It is an honor for me to be here and an opportunity to make a contribution, and I am grateful. Thank you for inviting me.

I would like to make three points. The first is that under the Clinton bill, universal coverage is financed with a regressive antiurban tax. There has been a great deal of discussion about the antiemployment nature of the financing, but I would like to focus on these two other qualities of it.

Second, the bill is designed to push most Americans into HMOs, and yet, there is an historic failure of Government, Federal and State, to curb HMO cost-cutting practices that endanger patients.

Third, I would like to offer an observation about how the plan will work for most Americans, what it will mean when they go to the doctor's office, and how that will imperil their privacy and also ultimately make fee-for-service or choose-your-own-doctor insurance very hard to get.

So let me start with the financing mechanism. If you live in or near a city, good luck. The bill requires States to create health alliance regions, similar to election districts, and I am pointing that out because this will be quite meaningful. How those alliance lines are drawn will determine which areas of a State are hit with the highest health care premiums because they are shouldering the cost of health coverage for the inner-city poor.

The system promises to pit black against white, poor against rich, and city against suburb. The average treatment cost of a baby born addicted to drugs is \$63,000 just to bring that baby home from the hospital. Because of community rating, anyone who lives in an urban alliance is going to pay the highest premiums and get the least amount of health care, regardless of his own health or behavior. Part of this premium will cover his own care, but part is a hidden tax to provide universal health coverage within the alliance, and, of course, some alliances will bear the especially heavy burden.

Everyone will figure out that you get the least amount of health care and pay the highest premiums if you live in an alliance with inner-city problems. So this bill will be an incentive for employers to abandon cities and relocate.

Considering the number of court battles when States draw election districts, lawsuits over medical gerrymandering are inevitable. The plan sets out the rules on how those lines are to be drawn—they are right here on page 99—remarkably similar to section 2 of the Voting Rights Act for all of you who have struggled with that for over a decade.

The States "may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socioeconomic status, disability or perceived health status." An alliance that includes a consolidated metropolitan statistical area within a State is presumed to be in compliance. Home prices and

litigation fees are going to rise and fall, depending on which suburbs are sucked into these alliances with inner-city problems.

Now, to make matters worse, this bill is financed with a regressive tax. The person who earns \$50,000 a year and the fat cat who earns \$500,000 a year is going to be making the same contribution toward the health care for their inner-city poor. Also, the bill would shift cost now paid partly by the Federal Government to the local alliances.

For example, the bill halts what are called Medicaid-only payments for the ill. In New York City, 387,450 people received those payments every year, an average of \$13,000 per person. The total bill in New York City, and this is for the Federal and State contribution, is \$4.9 billion a year. Under the Clinton bill, those people are folded into the community-rated system, and their health care needs, which on average are three times as great as the ordinary New Yorkers, will have to be met out of that pot into which everybody's premiums are paid.

The costs taken off the Federal budget are called savings by the administration, but this cost amounts to a new tax on the backs of urban employers and residents. I believe in universal health coverage. I would like to see it accomplished, but making urban residents and businesses pick up the tab will devastate cities.

The second point regarding HMOs, under the Clinton plan, the Federal Government uses price controls on premiums to curb dollars paid into the health care system. It is a system designed to encourage most Americans to sign up for managed care, prepaid health care. Limiting how the health care dollars are spent is a job taken on, in part, by alliance officials who will oversee the dwindling fee-for-service of indemnity sector, but mostly, it is a job taken on by HMO administrators who will do the lion's share of rationing.

Now, HMOs already have a track record of controlling patient access to physicians and high-tech care, and current HMO cost-cutting methods are already drawing criticism from Congress, from the General Accounting Administration who has written several reports on it, from Consumers Reports—see August 1992—and from many worried doctors.

The Clinton bill's premium caps will compel HMOs to use ever more stringent methods of limiting care, but the bill omits any safeguards to protect patients from these abusive practices, and I would like to focus on just one, if I can go on. May I?

Mr. McDERMOTT. Why not finish?

Ms. McCAUGHEY. Pardon me?

Mr. McDERMOTT. Go ahead.

Ms. McCAUGHEY. Thank you.

For example, missing from the bill is an effort to put a stop to the withhold. This is a pervasive HMO practice of punishing doctors financially for providing the care they believe their patients need. Almost all of for-profit HMOs, those operated by Aetna, Metlife, Prudential, Oxford—not Cigna—withhold between 10 and 25 percent of a doctor's payments per year, whether the doctor is on a salary or it takes a per-capitated fee for each patient signed on or a fee per clinical visit, but whatever the arrangement, the HMO withholds between 10 and 25 percent of what the doctor

earns during the year seeing HMO enrollees and returns that money to the doctor only if the doctor meets HMO targets for limiting patient access to tests, referrals to specialists, and hospitalization.

Now, the doctors with whom I have spoken, many, many have told me that these targets are so stringent that they don't know any doctor who has ever gotten his entire withhold back at the end of the year. What does that mean? It means that whatever tests or procedures a doctor orders for his patient comes out of his own pocket at the end of the year, and this withhold mechanism has caused a surge in dangerous hallway consultations, where one doctor, a primary care doctor or an internist will stop a specialist, like a pulmonologist in the hallway and say, "I have a patient with breathing problems, and I will try and describe the patient's symptoms and ask the pulmonologist what to do about it." Why isn't he just referring this patient to the pulmonologist for an examination? Because he doesn't want points against his withhold. The trouble is that he may forget to tell the pulmonologist that his patient is 86 years old or also has diabetes.

Will the Government protect people once they are enrolled in large numbers in these HMOs? The Clinton bill establishes two national boards to develop quality standards and depends on alliance officials to enforce them, but the history shows that Federal and State officials have failed to protect the patients they have encouraged to enroll in HMOs.

For example, in 1990, Florida newspapers were filled with lurid accounts of abuses by a Humana medical plan, an HMO paid to care for the elderly and to reduce Medicare costs. Congress ordered an investigation of Humana's performance. Here it is. Janet Shikles, in charge of the probe for the General Accounting Office, testified about the company's failure to order the diagnostic test that patients needed and failure to follow up on abnormal test results.

Consumers Reports in August 1992 did a similar investigation of the shortcomings of pilot Medicare HMO programs in Florida and concluded that government oversight was, in their words, lackadaisical.

A nationwide investigation for Congress by the GAO drew the same conclusion. Senator John Heinz, the late Senator John Heinz, pointed out in his summary of the report that only 21 of 57 HMOs investigated received a passing grade.

I will conclude in just a moment.

So he warned then in 1990 that government has given a priority to promoting enrollment in HMOs and has not given equal priority to monitoring what happens to people after they have enrolled.

Far from protecting patients in HMOs, the Clinton bill ties the hands of lawmakers who want to pass protective legislation. I refer you to page 238 in which the bill preempts State laws protecting consumer choice, enabling patients to choose, for example, the hospital they think is best or the pharmaceutical supplier.

Maybe you can ask me about the third point if we have time for questioning because I think that is also important.

[The prepared statement follows:]

TESTIMONY OF ELIZABETH P. McCaughey
JOHN M. OLIN FELLOW
MANHATTAN INSTITUTE

NO EXIT

If you are not worried about the Clinton health bill, keep reading. If the bill passes, you will have to settle for one of the low-budget health plans selected by the government. The law will prevent you from going outside the system to buy basic health coverage you think is better, even after you pay the mandatory premium (see the bill, page 244). The bill guarantees you a package of medical services, but you can't have them unless they are deemed "necessary" and "appropriate" (pages 90-91). That decision will be made by the government, not by you and your doctor. Escaping the system and paying out-of-pocket to see a specialist for the tests and treatment you think you need will be almost impossible. If you walk into a doctor's office and ask for treatment for an illness, you must show proof that you are enrolled in one of the health plans offered by the government (pages 139, 143.) The doctor can be paid only by the plan, not by you (page 236). To keep controls tight, the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans (page 236).

The administration states that the bill will not lower the quality of your medical care or take away personal choices you now make. This statement goes right to the issues that matter most. How true is it? To help you decide, here is a guide to the 1,364-page Health Security Act.

The Law Will Make You Get Health Care Through Your "Alliance." Under the bill, unless you get Medicare, military benefits or veteran's benefits, or you or your spouse work for a company with more than 5,000 employees, you must enroll in one of the limited number of health plans offered by the "regional alliance" where you live (page 15). Regional alliances are government-run monopolies that select health plans, collect premiums from residents and their employers and pay most of the money to HMOs and insurers. If you fail to enroll, or the plan you choose is oversubscribed, alliance officials will assign you to one (pages 144, 146). The goal is to curb health care spending by limiting what every American is allowed to pay for health insurance. Restricting how much people can pay for insurance limits how much money is in the pot to take care of them when they're sick.

The Health Care You Can Get Will Be Limited. Under the bill, A National Health Board—seven people appointed by the president—will decide how much the nation can spend on health plans beginning in 1996 (the baseline year). Based on that national budget, the board will set a budget for each region and a ceiling can cost. Regional alliance officials cannot permit the average premium paid in the region to exceed the ceiling. (pp. 1,000-1,005) Alliance officials are empowered to exclude any plan that costs 20% more than the average plan (p. 132). They will have to apply the 20% rule virtually all the time. In order to offer plans that exceed the 20% rule, there would have to be others offered at well below the averaged priced plan. That is unlikely. The bill pegs annual increases in premium prices to an inflation factor based on the Consumer Price Index (pp. 256, 984-7, 990, 995), well below annual increases in current demand for medical services.

Putting price controls on premiums to limit the amount of money in the health care system might wring out waste during the first year or two, but there is no doubt it will cause hardship later on. Seventy-seven million baby boomers will be reaching the age when they need more medical care. Increasing numbers of teen pregnancies and low-birth-weight babies also will require more health care dollars—\$158,000 on average for each severely underweight newborn. Even the bill's authors anticipate that restricting the dollars available for health care in the teeth of these trends will produce grave shortages: the bill provides that when medical needs outpace the budget and premium money runs low, state governments and insurers must make "automatic, mandatory, nondiscretionary reductions in payments" to doctors, nurses and hospitals to "assure that expenditures will not exceed budget" (pages 113, 137).

Above a threshold level of quality, officials will approve health plans based on lowest cost, not highest quality, to stay under the premium ceiling set by the National Health Board, explains Cara Walinsky of the Health Care Advisory Board and Governance Committee, which advises 800 hospitals worldwide. This is why Anthony L. Watson, chief executive of the Health Insurance Plan (HIP) of Greater New York, is optimistic. If the Clinton bill passes. "New York is mine," he told *The New York Times*, "I'm going to be the lowest-cost plan "HIP, with a physician staff that is 57 percent foreign-trained, already has what that newspaper calls "the image of being the least desirable health care option for city workers and others who cannot afford anything more."

Staying With the Doctors You Use Now Will Be Hard. Deciding for yourself when to see a specialist or get a second opinion and selecting the hospital you think is best will be even harder. The bill is designed to push people into HMOs, which restrict your choice of physicians and hospitals, and use gate-keepers to curb the use of specialists, expensive tests and costly high-tech treatments. What most of us call fee-for-service (choose-your-own-doctor) insurance will be difficult to buy. The ceiling on premiums and the 20 percent rule will eliminate most fee-for-service plans, which tend to be more expensive than their prepaid counterparts. Although the Clinton administration insists that Americans always will be able to choose fee-for-service insurance, experts, such as Dr. John Ludden, medical director of the Harvard Community Health Plan, say that option will "vanish quickly."

Even where it is possible to buy fee-for-service insurance, it will be hard to find doctors practicing on that basis. According to Walinsky, the Clinton proposal contains "very strong incentives" against fee-for-service "on the consumer side but also on the provider side." Price controls on doctors' fees and other regulations will push doctors to give up independent practice and sign on with HMOs. We've been told that the government won't be putting price controls on doctors, but the bill limits what health plans can pay physicians and prohibits patients from paying their doctors directly. Alliance officials post a schedule of fees, and it is illegal for doctors to take more (pages 134, 236).

In addition, alliance officials set yearly limits on payments to fee-for-service doctors in each field of medicine, like cardiology or pulmonology. What if a flu epidemic causes pulmonologists to see more patients with breathing problems than the region's budget allows? The bill compels insurance plans to slash doctors' fees or cut off their payments entirely until the next year "to assure that expenditures will not exceed the budget" (page 137).

Can you pay any doctor any price for any service you want? Although it is possible to buy cosmetic surgery, psychotherapy or other uncovered services out-of-pocket, the bill prohibits doctors from accepting payments directly from you for the basic kinds of medical care listed in the Clinton benefit package. Below are the regulations barring doctors from taking your money. If you go to a doctor for treatment, the doctor will be paid by your health plan. That is true no matter what kind of health plan you are enrolled in. The doctor is prohibited from accepting payments from you (except fixed co-payments) for any basic medical services listed in the Clinton benefit package. That applies to doctors treating patients in HMOs and doctors outside HMO networks. Doctors outside HMOs must submit charges for your care to your health plan, accept reimbursement based on the government's schedule of price-controlled fees and report your visit according to the requirements of title V of the bill, establishing the national electronic data bank:

Sec. 1406(d) DIRECT BILLING—A provider may not charge or collect from an enrollee amounts that are payable by the health plan...and shall submit charges to such plan in accordance with any applicable requirements of part 1 of subtitle B of title V (relating to health information systems).

Are you allowed to pay a surgeon more, in hopes of getting the most expert, experienced care? No:

Sec. 1406(d)(1) PROHIBITION OF BALANCE BILLING—A provider may not charge or collect from an enrollee a fee in excess of the applicable payment amount under the applicable fee schedule (page 236)...**Sec. 1406(d)(3) AGREEMENTS WITH PLANS**—The agreements...between a health plan and the health care providers providing the comprehensive benefit package to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in paragraph (1) (page 237).

The White House attacks the use of the phrase "price controls on doctors' fees" in my article. "Wrong says the White House. "There are no price controls in the president's plan. Price controls—calling for government micromanagement of every health care service, doctor's fees, drug technology and product—were considered and specifically rejected."

The text of the bill proves there are price controls on health plan premiums, new drugs and doctors' fees. Here are the price controls on doctors' fees:

Sec. 1322(c) ESTABLISHMENT OF FEE-FOR-SERVICE SCHEDULE

(1) **IN GENERAL**—each regional alliance shall establish a fee schedule setting forth the payment rates applicable to services furnished during a year to individuals enrolled in fee-for-service plans (or services furnished under the fee-for-service component of any regional alliance health plan) (page 134)....

(4) **ANNUAL REVISION**—A regional alliance... shall annually update the payment rates provided under the fee schedule (page 135).

The White House says "It is not clear why a patient would want to pay a doctor "directly" for any services that their insurance company is obligated to buy." One reason is privacy. Evading government regulations and paying the doctor directly would allow you to keep your personal medical problems out of the national data bank.

Will your personal medical history be stored in a national data bank? The White House says "not true" and "patently untrue" to my statement that "the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans. The administration argues that although "physicians may be required to submit data...for the purpose of improving quality and assessing treatments and outcomes," the bill "prevents against tying this data to specific individuals."

The text of the bill proves that the administration is mistaken. Information about you physical and mental health and any treatments or tests you have will be entered in a national data network and linked to you through you health security number. Here is what the bill says: The National Health Board will establish an "electronic data network" with regional centers to collect, compile and transmit information. The information expressly includes "clinical encounters," that is, when a physician treats a patient (page 861). A doctor who treats you (except for an uncovered service such as dental work or cosmetic surgery) and does not record your "clinical encounter" on the standardized form and submit it to your health plan will be fined up to "\$10,000 for each such violation" (pages 236, 885-6). As the data about you travel from doctor's office to the health plan, and then to the national electronic data network, this information continues to be tagged with your "unique identifier number."

The bill leaves no doubt that the network contains "individually identifiable health information," which is defined in the bill to include your "past, present or future physical or mental health" and health care provided to you (page 877). To protect your privacy, the bill offers this vagueness:

All disclosures of individually identifiable health information shall be restricted to the minimum amount necessary to accomplish the purpose for which the information is being disclosed (page 873)... (You) have the right to receive a written statement concerning...the purposes for which individually identifiable information provided to a health care provider, a health plan, a regional alliance, a corporate alliance or the National Health Board may be used or disclosed by, or disclosed to, any individual or entity (page 874).

It would be unfair to suggest that the bill's authors are unconcerned about privacy. The bill mandates that the National Health Board will "promulgate standards respecting the privacy of individually identifiable health information that is in the health information system" within two years and propose privacy legislation within three years (pages 871, 876). But doctors must report their patients' personal medical information to a national data bank or risk harsh penalties, and the information continues to be individually identifiable.

HMOs Do the Job of Rationing. Under the Clinton bill, the federal government uses price controls on premiums to curb dollars paid into the health care system. Limiting how those dollars are spent is a job shared by alliance officials who budget payments to doctors in the dwindling fee-for-service sector, and HMO administrators, who are expected to do the lion's share of health care rationing. Is "rationing" too strong a word? Not according to Dr. John Ludden, who HMO serves 570,000 people. He predicts that "price controls on premiums will drive us straight to rationing at bedside." Princeton Professor Paul Starr, a key designer of the Clinton plan, prefers to say that premium caps will induce "a different frame of mind" in both doctors and health care administrators. "They will have to manage under constraint."

HMOs already have a track record of tightly controlling a patient's access to physicians. At Kaiser Permanente, the first person a sick patient sees is the "advice nurse," who makes the decision whether a doctor is needed. In HMOs, the ratio of physicians to members averages 1 to 800, about half the ratio of physicians to the general population. Specialists are particularly hard to see.

Current HMO cost-cutting methods already are drawing criticism from Congress, government investigators and worried doctors. The Clinton bill's premium caps will compel HMOs to use even more stringent methods of limiting care, but the bill omits any safeguards to protect patients from abusive practices.

For example, missing from the bill is any effort to put a stop to "the withhold," the pervasive HMO practice of punishing doctors financially for providing care they believe their patients need. Almost all large, for-profit HMOs including those operated by Aetna, MetLife, Oxford and Prudential (but not Cigna) withhold between 10 percent and 25 percent of a doctor's compensation until year's end, and return it only if the doctor has met HMO targets for limiting patient tests, referrals to specialists and hospitalizations. Doctors report that targets are so stringent that HMOs almost always keep part of the withhold, which means that what a doctor orders for a patient comes out of the doctor's own pocket at the end of the year.

The withhold has caused a surge in dangerous "hall-way consultations," according to Dr. Alan Jasper, a pulmonologist and critical care specialist at St. Vincent's Medical Center in Los Angeles. Other doctors stop Jasper in the hospital corridors, describe their patient's breathing problem and seek a diagnosis, in order to avoid referring the patient for a specialty consultation and incurring points against the withhold. The danger, says Jasper, is that the other doctor might fail to mention a critically important aspect of the patient's condition.

The withhold motivates primary care doctors to take a "we'll see how you feel next week" or "let's try this first" approach, even if it means additional worry and needless suffering for the patient. At a Humana-owned HMO in San Antonio, for example, a 40-year-old woman with back pain was told by the orthopedist that she needed an MRI. But her primary care doctor rejected the specialist's request for the tests, saying the patient would have to try something less expensive, and sent her for acupuncture, followed by months of hot packs and physiotherapy. When nothing worked, the gate-keeper authorized the MRI, which revealed that the woman needed a lumbar discectomy (disc removal), as the orthopedist had suspected. The story was related by the woman's surgeon. Dr William V. Healey, a clinical professor at the University of Texas, who said the lesson was that HMO cost-cutting incentives such as the withhold fail to account for the far graver cost—the months a patient is home from work worried and in pain.

Another HMO cost-cutting strategy that makes doctors and patients worry is the utilization review—a sick patient must wait while the doctor telephones a utilization review company, describes the symptoms and medical history to a nurse or clerk seated at a computer terminal and hopes for an O.K. to proceed with tests and treatment.

Three hundred and fifty utilization review companies that claim to slash health care costs sell their services to HMOs, hospitals and others at a rate of \$1 to \$3 per patient reviewed. It's a \$7 billion industry. Such "cookbook medicine" ignores the non-average, abnormally sick patient who may need more intense treatment than the computer program recommends. It also discounts the value of examining a patient, and ignores the physician's judgment and expertise. Dr. Jerome Groopman, head of oncology and hematology at the New England Deaconess Hospital in Boston, says, "It's an 800 number. They don't know me from Adam!"

"Horror stories abound" about utilization review, according to a 1993 report for the National Association of Attorneys General. Doctors' treatment plans are "rejected by inadequately trained personnel," according to the report, and utilization review companies refuse to give reasons for their decisions, even to doctors, because it is presumed doctors would figure out ways to get around the review guidelines once they were known.

Even when doctors' recommendations are ultimately approved, it can take weeks longer to diagnose and begin treating an HMO patient than a patient with fee-for-service insurance, Jasper explains, because of the successive delays in getting each test approved. One HMO patient with coughing trouble was given antibiotics by his primary care doctor, who thought the problem was pneumonia. The patient lost thirty-five pounds while waiting from October 27 to December 24 for an O.K. to see Dr. Jasper, then to have a CAT scan and lung biopsy, and finally to learn that the correct diagnosis was a lung fungal disease. Jasper said he could have had a fee-for-service patient on anti-fungal medicine within fourteen days, instead of nine weeks.

The Attorneys General report urges state lawmakers to look into curbing utilization review in HMOs. In contrast, the Clinton bill calls utilization review a "reasonable restriction" on patient care and expressly includes it for doctors treating patients with fee-for-service insurance as well (page 134).

The Government Won't Protect You From HMO Abuses. If most Americans are moved into HMOs, who will ensure that they get good health care? The Clinton bill establishes two national boards to develop quality standards and depends on alliance officials in each state to enforce them (pages 843-844). But history shows that federal and state officials have failed to protect patients from HMO abuses, even in small pilot programs.

In 1990 Florida newspapers printed lurid accounts of abuses by Humana Medical Plan, an HMO paid to care for the elderly under a small, experimental program to reduce Medicare costs. Congress ordered an investigation of Humana's performance, and Janet Shikles, in charge of the probe for the General

Accounting Office testified about the company's failure to order appropriate diagnostic tests and failure to follow up on abnormal test results." *Consumer Reports* (August 1992) also investigated the shortcomings of the pilot Medicare-HMO program in Florida, and concluded that government oversight was "lackadaisical."

A nationwide investigation for Congress drew the same conclusion. Pointing out that only twenty-one of fifty-seven HMOs investigated received a passing grade, the late Senator John Heinz warned that the priority "has been to promote enrollment in HMOs and we have not given equal priority to monitoring what happens" to people "after they have enrolled."

Far from protecting patients in HMOs, the Clinton bill ties the hands of state lawmakers who want to pass protective legislation. Some states recently have enacted laws to safeguard choices patients want to make for themselves, such as which hospital or pharmacy to use. HMOs protest that these laws hobble cost containment, and the Clinton administration apparently agrees. The Clinton bill pre-empts state laws protecting patient choice (page 238).

You'll Get More Primary Care Than High-Tech Medicine, and That's Not Good News. Will patients get the care they need when gatekeepers limit their access to specialists and high-tech medicine, as the Clinton bill intends? The evidence strongly suggests that low-tech care will not be good enough. People with heart disease, for example, will suffer. HMOs already ration high-tech care to heart attack patients, according to a study in *The New England Journal of Medicine* (December 1993). HMO patients hospitalized with coronary disease (myocardial infarction, unstable angina, angina pectoris or ischemic heart disease) are 30 percent less likely to be given bypass surgery or a coronary angioplasty (declogging of the arteries) than similarly sick patients with fee-for-service insurance. Another recent study by Duke University points to the consequences of such low-tech care. In the study, American heart attack patients who tended to be treated with three costly, high-tech procedures--catheterization (inserting a thin tube into the heart for diagnosis), angioplasty and bypass surgery--recovered far better than Canadian heart attack patients, who had less access to the procedures. American patients, who were twice as likely to undergo the procedures, tended to have a better quality of life after a heart attack. Canadians suffered more recurring pain, felt more depressed and were less able to go back to work and pick up their old activities. Dr. Robert Califf says the Duke study may help people understand "the implications of reducing services in a health care system."

Is it true that we need less care by specialists? Not according to the National Institutes of Health, which recently issued a warning that patients with many common conditions should be treated routinely by a renal (kidney) specialist. According to the NIH panel, primary care doctors frequently are overlooking the early signs of kidney failure and are hanging on to patients too long. Patients should be referred to specialists for dialysis sooner, said the NIH, before it is too late to save their lives. Twenty-five percent of kidney patients who don't receive dialysis until it is an emergency die. Dr. C. Craig Tisher, chairman of the NIH panel, warned that patients with high blood pressure, diabetes, weight problems and metabolism abnormalities should be regularly cared for by a renal specialist, not only a primary care doctor.

In the short run, the Clinton bill depends on HMOs to limit access to specialists and high-tech care. As a longer-term strategy to limit such care, the Clinton bill seizes control of medical education and requires that by 1998, no more than 45 percent of young doctors be permitted to go on to advanced training in specialty. Specialty programs at leading medical schools will be downsized. Restricting medical education by government fiat undoubtedly will reduce the consumption of expensive, cutting-edge care. Doctors who are not trained in sophisticated technology cannot use it. But preventing doctors from learning about the most advanced medical procedures is a lethal way to curb health care consumption. Keeping doctors uninformed could not possibly be an improvement.

Racial quotas in medical training. The White House calls such a suggestion "ridiculous," but the bill shows it is true. Government will allocate graduate training positions at the nation's teaching hospitals based on race and ethnicity. In determining how many training positions teaching hospitals will have, the National Council on Graduate Medical Training will calculate the percentage of trainees at each teaching hospital "who are members of racial or ethnic minority groups" and which minority trainees are from groups "under-represented in the field of medicine generally and in the various medical specialties" (page 515).

If You Live In or Near a City, Good Luck. The bill's biggest surprise is who bears the cost of universal health coverage. The bill requires states to create health alliance regions—similar to election districts. How those alliance lines are drawn will determine which areas of the state are hit with the highest health care premiums, because they are shouldering the costs of health coverage for the inner city poor. The system promises to pit black against white, poor against rich, city against suburb.

The average treatment cost of a baby born addicted to drugs is \$63,000. Because of community rating, anyone who lives in an urban alliance is going to pay high premiums, regardless of his health or behavior. Part of the premium covers his own care; part is a hidden tax to provide universal health coverage within the alliance. Some alliances will bear especially heavy social burdens, others will not. Everyone will figure out that you get more health care for your dollar or pay lower premiums in an alliance without inner city problems. The bill will be an incentive for employers to abandon cities and relocate.

Considering the number of court battles when states draw election districts, lawsuits over "medical gerrymandering" are inevitable. The plan sets out rules that will be dissected in courtrooms across the nation: States "may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socioeconomic status, disability, or perceived health status." An alliance "that includes a Consolidated Metropolitan Statistical Area within a State is presumed to" be in compliance. (Page 99) Home prices and litigation fees will rise and fall depending on which suburbs are sucked into a metropolitan alliance and which escape.

To make matters worse, the bill would shift costs now paid partly by the Federal Government onto the local alliances. For example, the bill halts "Medicaid only" payments for the ill (50 percent of the \$4.9 billion distributed to New York City beneficiaries in 1991) and disproportionate share payments to urban hospitals that treat the poor (\$807 million to New York City hospitals the same year). Costs taken off the federal budget are called "savings" by the Clinton administration, but the cost shift amounts to a new tax on urban residents and employers, hidden inside their "premiums." Universal health coverage is an important goal, but making urban residents and businesses pick up most of the tab will devastate cities.

Before Signing On, You Should Know The Clinton bill will prevent people from buying the medical care they need. Price controls on premiums will push most Americans into HMOs and pressure HMOs into sharply cutting access to specialists and effective, high-tech cures. Price controls on doctors' fees and regulations tying doctors' hands will curb the care physicians can give patients. Price controls on new drugs will keep people over 65 from getting the medications that can help them. Most important, government controls on medical education will limit what future doctors know, costing lives and suffering no one can calculate.

The administration often cites two statistics—America's relatively high infant mortality rate and its lower life expectancy—to support the need for the Clinton health bill. But these have almost nothing to do with the quality of American medical care. Both statistics reflect the epidemic of low-birth-weight babies born to teenage and drug-addicted mothers, as well as the large number of homicides in American cities and drug-related deaths.

In fact, if you are seriously ill, the best place to be is in the United States. Among all industrialized nations, the United States has the highest cure rates for stomach, cervical and uterine cancers, the second highest cure rate for breast cancer and is second to none in treating heart disease. In other countries that spend less, people who are sick get less care, are less likely to survive and have a poorer quality of life after major illness. Consider what happens in Canada, whose health care system often is held up as a model for the United States. In Canada medical technology is rationed to dangerously low levels. The United States has 3.26 open-heart surgery units per million people; Canada has only 1.23 units per million. Cardiovascular disease is Canada's number one health problem, yet open-heart surgery units and catheterization equipment are kept in such short supply that the average wait for urgent (not elective) surgery is eight weeks. The shocking result is that in Canada, a cardiac patient is ten times as likely to die waiting in line for surgery as on the operating table. In the United States, there is no wait.

The choice is not between the Clinton bill and the status quo. Members of Congress should read this bill, instead of relying on what they hear, and then turn their attention to alternatives sponsored by Democrats and Republicans. These alternatives attack the worst abuses by health insurance companies, reform liability laws that force doctors to practice wasteful, defensive medicine and devise ways to make insurance affordable if you don't work for a large company. Congress also should consider ways to provide insurance for those who cannot afford it, and level with the public about what universal coverage will cost. Whatever the price, ultimately, it will be less expensive than the consequences of the Clinton bill.

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The admission by the ANC's longtime standard-bearer among coloreds, the Reverend Allan Boesak, to having an affair with a white reporter has further compromised its reputation. Achmat Davids, a colored ANC candidate for the Western Cape's regional legislature, admits, "This is a very religious community. Many have not forgiven Allan Boesak and question his moral right to be a leader if he cannot uphold God's law." After a prolonged struggle, Boesak was chosen as the ANC's candidate for premier in the Western Cape, but as ANC spokesman Pallo Jordan said recently, "His credibility in the colored community is not terribly high."

The N.P., billing itself as a "Christian Democratic law-and-order, free-market alliance," has seized on these perceived weaknesses. De Klerk, accompanied by his wife, kicked off his campaign in Genadendal (Valley of Grace), a predominantly colored town founded as a Moravian Church mission in the eighteenth century. A recent N.P. advertisement in the progressive newspaper *South* disingenuously predicted that if the ANC gained power, Winnie Mandela, "convicted of kidnapping," would become "minister of law and order" or even of "child welfare." N.P. stump speeches slam her statement that "the matchbox is our weapon," and condemn the role of ANC supporters in the kangaroo court trials and necklacings of black policemen and suspected informers in the Cape squatter settlements of Crossroads and Khayelitsha. A campaign flyer declares, "Don't vote for an intimidator."

The N.P. is betting that such appeals will have particular resonance with coloreds, who live closer to black areas than whites. In particular, the N.P. has attacked the ANC for condoning the seizure by black squatters of houses intended for coloreds in the Cape Town suburb of Mitchell's Plain. The N.P.'s newsletter calls the ANC an "architect of anarchy."

In South Africa discussions of policy are rarely free from questions of racial identity. During apartheid, the people of the Cape were encouraged to believe that because they did not have a black majority, they would not face the same political, social and moral reckoning as the rest of the country. Through a labor system that gave them preference over blacks, coloreds were encouraged to feel superior to and distinct from them. McKenzie argues that the perception of coloreds as the "stepchildren" of whites is a thing of the past. But he admits that he fears black oppression as much as white. For colored leaders in the ANC, the very notion of a colored identity separate from a black or African one is a pernicious relic of apartheid—a relic that a colored-elected N.P. regional government in the Western Cape would institutionalize. In the words of the renowned colored jazz pianist Abdullah Ibrahim, "I have to keep reminding people that Cape Town is in Africa. They've repressed and denied every part of it. There's a massive identity crisis."

PETER BEINART is a former TNR reporter-researcher.

Clinton's plan on the ropes.

SHE'S BAAACK!

By Elizabeth McCaughey

On January 31 the White House press office released a statement questioning the accuracy of my recent article in TNR ("No Exit," February 7, 1993). I welcome this opportunity to engage in a dialogue with the White House about the content of its health bill. As I did in my original article, I will be documenting my description of the bill—and my point-by-point rebuttal of their arguments—with page numbers from the November 20, 1993, version. If White House representatives challenge the accuracy of my description again, I hope they will provide page numbers, too, so that TNR readers can compare the evidence and decide for themselves.

Most of the White House challenge focused on this paragraph from my article:

If the bill passes, you will have to settle for one of the low-budget health plans selected by the government. The law will prevent you from going outside the system to buy basic health coverage you think is better, even after you pay the mandatory premium (see the bill, page 244). The bill guarantees you a package of medical services, but you can't have them unless they are deemed "necessary" and "appropriate" (pages 90-91). That decision will be made by the government, not by you and your doctor. Escaping the system and paying out-of-pocket to see a specialist for the tests and treatment you think you need will be almost impossible. If you walk into a doctor's office and ask for treatment for an illness, you must show proof that you are enrolled in one of the health plans offered by the government (pages 139, 143). The doctor can be paid only by the plan, not by you (page 236). To keep controls tight, the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans (page 236).

The White House responded:

"There is nothing in this Act to prohibit any individual from going to any doctor and paying, with their own funds, for any service." "Under the Act, you can pay 'out-of-pocket[sic]' for anything you want at any time, to any physician or hospital willing to treat you." Price controls on doctors' fees? "That is wrong," according to the White House. "There are no price controls...."

How accurate are these statements from the White House? The text of the bill proves they are untrue.

Can you pay any doctor any price for any service you want? Although it is possible to buy cosmetic surgery, psychotherapy or other uncovered services out-of-pocket, the bill prohibits doctors from accepting payments directly from you for the basic kinds of medical care listed in the Clinton benefit package. Below are the reg-

ulations barring doctors from taking your money. If you go to a doctor for treatment, the doctor will be paid by your health plan. That is true no matter what kind of health plan you are enrolled in. The doctor is prohibited from accepting payment from you (except fixed copayments) for any basic medical services listed in the Clinton benefit package. That applies to doctors treating patients in HMOs and doctors outside HMO networks. Doctors outside HMOs must submit charges for your care to your health plan, accept reimbursement based on the government's schedule of price-controlled fees and report your visit according to the requirement of title v of the bill, which establishes the national electronic data bank:

Sec. 1406(d)(2) DIRECT BILLING—A provider may not charge or collect from an enrollee amounts that are payable by the health plan ... and shall submit charges to such plan in accordance with any applicable requirements of part 1 of subtitle s of title v (relating to health information systems).

Are you allowed to pay a surgeon more, in hopes of getting the most expert, experienced care? No:

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The White House attacks the use of the phrase "price controls on doctors' fees" in my article. "Wrong," says the White House. "There are no price controls in the president's plan. Price controls—calling for government micromanagement of every health care service, doctor's fee, drug technology and product—were considered and specifically rejected."

But the text of the bill proves there are price controls on health plan premiums, new drugs and doctors' fees. Here are the price controls on doctors' fees:

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(1) IN GENERAL—each regional alliance shall establish a fee schedule setting forth the payment rates applicable to services furnished during a year to individuals enrolled in fee-for-service plans (or services furnished under the fee-for-service component of any regional alliance health plan) (page 134)....

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The White House says "It is not clear why a patient would want to pay a doctor 'directly' for services that their [sic] insurance company is obligated to buy." One reason is privacy. Evading government regulations and paying the doctor directly would allow you to keep your personal medical problems out of the national data bank.

Will your personal medical history be stored in a national data bank? The White House says "not true" and "patently untrue" to my statement that "the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans. The

administration argues that although "physicians may be required to submit data ... for the purpose of improving quality and assessing treatments and outcomes," the bill "prevents against tying this data to specific individuals."

The text of the bill proves that the administration is mistaken. Information about your physical and mental health and any treatments or tests you have will be entered in a national data network and linked to you through your health security number. Here is what the bill says: the National Health Board will establish an "electronic data network" with regional centers to collect, compile and transmit information. The information expressly includes "clinical encounters," that is, when a physician treats a patient (page 861). A doctor who treats you (except for an uncovered service such as dental work or cosmetic surgery) and does not record your "clinical encounter" on the standardized form and submit it to your health plan will be fined up to "\$10,000 for each such violation" (pages 236, 885-886). As the data about you travel from your doctor's office to the health plan, and then to the national electronic data network, this information continues to be tagged with your "unique identifier number."

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All disclosures of individually identifiable health information shall be restricted to the minimum amount necessary to accomplish the purpose for which the information is being disclosed [page 873].

and this:

[You] have the right to receive a written statement concerning ... the purposes for which individually identifiable information provided to a health care provider, a health plan, a regional alliance, a corporate alliance or the National Health Board may be used or disclosed by, or disclosed to, any individual or entity (page 874).

It would be unfair to suggest that the bill's authors are unconcerned about privacy. The bill mandates that the National Health Board will "promulgate standards respecting the privacy of individually identifiable health information that is in the health information system" within two years and propose privacy legislation within three years (pages 871, 876). But contrary to the White House statement, doctors must report their patients' personal medical information to a national data bank or risk harsh penalties, and the information in the bank remains individually identifiable.

Price controls on premiums will mean too little money to care for the sick Limiting how much money people can choose to pay for basic health coverage limits how much money is in the pot to take care of them when they are sick. That was the point of the ad on television that the First Lady criticized. A couple are discussing what price controls on premiums will mean, and the woman asks, "But what if there's not enough money?"

The bill's authors anticipate that restricting dollars available for health care will produce shortages: when medical needs outpace the budget and premium money runs low, state governments and insurers must make "automatic, mandatory, nondiscretionary reductions in payments" to doctors, nurses and hospitals to "assure that expenditures will not exceed budget" (pages 113, 137).

In a charge echoed by Michael Weinstein of *The New York Times*, the White House accused me of misleading readers by "implying that such a mechanism exists in the main proposal." The White House stated emphatically that "it does not." The White House and Weinstein argue that only under a single-payer system would payments to doctors and others be cut off if needs outpace the budget and premium money runs low. They expressly charge me with quoting the single-payer regulations and misrepresenting them to be rules for the "main" Clinton health proposal.

The text of the bill proves that the White House and Weinstein are wrong. Cutting or delaying payments to doctors, other health care workers and hospitals to stay in budget is an integral mechanism in the administration's bill, and one of the two passages I quoted (page 137) is from the "main proposal." It provides that if needs exceed budget and premium money runs low:

Sec. 1322(c)(2) PROSPECTIVE BUDGETING DESCRIBED . . . the plan shall reduce the amount of payments otherwise made to providers (through a withhold or delay in payments or adjustments) in such a manner and by such amounts as necessary to assure that expenditures will not exceed budget.

The government will decide what is "necessary" and "appropriate" care. The White House attacks as "wrong" and "very misleading" my statement that "the bill guarantees you a package of medical services, but you can't have them unless they are deemed 'necessary' and 'appropriate.'" The administration also says it is "untrue" that that decision will be made by the government, not by you and your doctor.

Let's look at the actual "bill":

Sec. 1141. EXCLUSIONS

(a) MEDICAL NECESSITY.—The comprehensive benefit package does not include

(1) an item or service that is not medically necessary or appropriate; or

(2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154 (pages 90-91).

Sec. 1154. ESTABLISHMENT OF STANDARDS REGARDING MEDICAL NECESSITY

The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(a)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

The bill uses the word "regulations," not "recommendations," to describe the National Health Board's decisions. The bill also grants the National Health Board power to change the preventive treatments guaranteed in the benefit package and decide at what age and how often you are entitled to tests and screenings, immunizations and check-ups (page 94). Regarding practice guidelines, the bill makes it clear that the National Qual-

ity Management Council will develop measures of "appropriateness of health care services" (page 839) and "shall establish standards and procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization" (page 848).

Racial quotas in medical training. The White House calls such a suggestion "ridiculous," but the bill shows it is true. Government will allocate graduate training positions at the nation's teaching hospitals based on race and ethnicity. In determining how many training positions teaching hospitals will have, the National Council on Graduate Medical Training will calculate the percentage of trainees at each teaching hospital "who are members of racial or ethnic minority groups" and which minority trainees are from groups "underrepresented in the field of medicine generally and in the various medical specialties" (page 515).

Protecting consumers or HMOs? The White House calls it "deliberately inaccurate" to say that the bill pre-empt important state laws protecting the ability of patients to choose the hospital they think is best and make other choices about their health care. Here is what the bill provides:

Sec. 1407. PRE-EMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS

(a) . . . no state law shall apply . . . if such law has the effect of prohibiting or otherwise restricting plans from—

(1) . . . limiting the number and type of health care providers who participate in the plan;

(2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;

(3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution; . . .

(6) requiring the use of single-source suppliers for pharmacy, medical equipment and other health products and services.

Fee-for-service will be almost impossible to buy. The White House labels it wrong to predict that fee-for-service insurance will be extremely hard to buy. They point to the provision that "in general, each regional alliance shall include among its health plan offerings at least one fee-for-service plan." But many doctors, hospital administrators and health insurance experts say confidently that in practice, because of the broader provisions of the bill, fee-for-service will seldom be available. I cited these experts in my article. Here are their reasons:

(1) Regional alliances cannot permit the average premium paid in the region to exceed the ceiling imposed by the National Health Board (pages 1,000-1,005). Fee-for-service insurance, which allows patients to get a second opinion when they have doubts and see a specialist when they feel they need one, generally costs more than prepaid health plans that control patient access to medical care.

(2) Regional alliance officials are empowered to exclude any plan that costs 20 percent more than the average plan (page 132). They will have to apply the 20 percent rule virtually all the time, in order to keep total spending on health plans below the ceiling imposed by the National Health Board. In order to offer

a plan that costs more than 20 percent above the average plan and still stay under the ceiling, there would have to be other plans offered at well below the average-priced plan. That is unlikely. The bill limits the annual increase in premium prices to the Consumer Price Index, which is significantly below current annual increases in medical spending. Insurers will have a difficult time staying under the premium ceiling, and certainly will not offer plans well below it.

(3) Regional alliance officials are empowered to set the fees for doctors treating patients on a fee-for-service basis, and it is illegal for doctors to take more. In addition, prospective budgeting limits what fee-for-service doctors can earn yearly, even if they see more patients and work longer hours to make up for reduced fees. As Cara Walinsky of the Health Care Advisory Board and Governance Committee, which advises 800 hospitals, explains, the Clinton bill contains "very strong incentives" against doctors practicing on a fee-for-service basis. For all these reasons, Dr. John Ludden, medical director of the Harvard Community Health Plan, predicts that fee-for-service will "vanish quickly."

Does supplemental insurance provide an "exit"? The bill requires you to buy one of the low-budget health plans offered by your regional alliance. You can't go outside the system to buy basic coverage you prefer, even after you pay the mandatory premium. Is supplemental insurance the way out? The White House states "there are no restrictions on the purchase of supplemental insurance." The fact is the bill contains two important restrictions

that will effectively close the door to better basic medical care: supplemental insurance cannot duplicate any of the coverage in the comprehensive benefit package, and it must be offered to "every individual who seeks" to buy it, regardless of health history or disability (page 244). Those two restrictions mean that the seriously ill will line up to buy it; insurers will not line up to sell it.

Finally, it is important to note one of the points the White House did not challenge: the Clinton bill is designed to push people into HMOs, which aim to limit patient access to specialized medicine and high-tech care. The premium price controls will pressure HMOs to use even more stringent methods of restricting care, yet the bill omits any safeguards to protect patients from abusive cost-cutting practices such as the withhold.

These facts, straight from the text of the bill, demonstrate the accuracy of my article "No Exit," and the appropriateness of its title. The White House would have you believe that its bill can stop rising health care spending and extend coverage to millions of uninsured Americans, without changing the quality and choice of the medical care you have now. Common sense suggests otherwise. A close reading of the bill proves it is untrue. Several alternatives by other Democrats and Republicans offer promising health insurance reform without limiting what you can buy and how much you can pay for it. It's time to give those bills a close look.

ELIZABETH MCCAUGHEY is John M. Olin Fellow at the Manhattan Institute.

Bentsen, Riley, Peña: victims of Clinton's style.

Mr. McDERMOTT. Thank you.
Mr. Schaeffer.

**STATEMENT OF LEONARD SCHAEFFER, CHAIRMAN AND
CHIEF EXECUTIVE OFFICER, BLUE CROSS OF CALIFORNIA**

Mr. SCHAEFFER. Thank you, Mr. Chairman, Mr. Thomas, members of the subcommittee. My name is Leonard Schaeffer. I am chairman and CEO of Blue Cross of California and chair of the National Institute for Health Care Management. I appreciate the opportunity to testify today.

Both of these organizations strongly support reform in the health care system. The challenge, though, is to develop a plan that meets the objectives of reform and that can be implemented in a pragmatic manner in States and communities throughout our Nation.

Based on my 20-year experience in government and in private health care organizations, including service as a State budget officer and as Administrator of the Health Care Financing Administration, I recognize that the pitfalls of reform reside in its implementation.

Mandatory, exclusive regional health alliances are the feature of the administration's plan that present the greatest obstacle to successful implementation. A single, government-run monopoly purchaser of health benefits in the community will have disastrous consequences. This structure will increase bureaucracy. It will inhibit innovation and, I believe, decrease accountability.

Alliances insert an unnecessary bureaucratic layer that will duplicate and complicate administrative functions. Alliances will eliminate one of the key sources of innovation which is the purchaser's drive to reduce costs. Finally, alliances diffuse the accountability for cost, quality, and service which will result in poorer outcomes, higher costs, and increased politicization.

In California, some of our legislators are pushing for a mandatory, exclusive Statewide alliance. That alliance would have a budget of over \$80 billion. That is twice the size of our State budget, the largest State in the Nation, and it would become the greatest concentration of economic power outside of Washington, D.C.

These problems are especially troublesome since mandatory alliances are not necessary to achieve the objectives of reform. Alternatives exist to meet the same objectives without requiring a new bureaucratic structure. My prepared statement contains a detailed review of how alliance functions can be replaced by more efficient alternatives.

Many States have already moved ahead with health care reform initiatives that are compatible with the goals of national reform. California, for example, provides an effective model for future reform. The State has a market based on increasingly competitive managed care systems. In 1993, California enacted significant legislative reform that restructured the small group insurance market.

The State also established a voluntary health alliance. As of December of this year, 1,900 groups were enrolled. About 22 percent of this voluntary alliance's new sales were to employers that previously were uninsured. So it is reaching out to the uninsured community.

I would like to note for your record that Blue Cross of California's own small group pool, which is growing more rapidly than the State-funded pool, had a 24-percent outreach to previously uninsured small groups. So the combination of a voluntary government pool and a competitive private sector results in outreach to the currently uninsured.

California's small employers can join the voluntary alliance or choose to purchase coverage directly from a health plan. This approach retains a role for employers that is essential if they are expected to pay 80 percent of the bill. In addition, the voluntary alliance administration costs are low because of its reliance on user fees. Those employers that choose to join the alliance pay for it. Those that don't, don't.

The administration's alliance structure is neither desirable nor, do I think, feasible. While the Cooper bill provides for smaller alliances, it still mandates these structures as the only source of health coverage. I think alliances should be kept voluntary and competitive to ensure that they are responsive to consumers. The Chafee-Thomas voluntary alliance proposal comes closest to the California model, a working model that has measurable results. Therefore, we urge you to consider this approach.

I want to briefly touch on only two other issues that could potentially undermine reform efforts. First, reform has to be sensitive to States such as California with problem economies. While other States are emerging from the recession, we are now in our 44th month. We understand that to reach out beyond the currently insured, some of you are considering mandates, and that may well be feasible and appropriate at some point. However, in California, a mandate would have a devastating impact on our economy.

The Lewin-VHI study on the impact of the President's reform plan in California predicted a loss of up to 80,000 jobs and concluded that "implementation of the [President's] health reform produces a mild recession" with "no sign of a recovery even 8 years after implementation." California can't take that.

Second, regulatory premium caps should be opposed. The history is clear: Caps like that don't work.

Finally, the private sector can and will innovate. Three years ago, Blue Cross of California set out to address the insurance needs of small groups. Today, we cover more than 1 million people in this market. Last month, we announced the guaranteed coverage program to guarantee health coverage to all currently uninsured individuals. We take all comers regardless of their health history. We do this voluntarily, and we would expect other California carriers to follow suit.

I am pleased to submit a detailed statement and would be happy to respond to your questions.

[The prepared statement and attachments follow:]

**STATEMENT OF LEONARD D. SCHAEFFER
BLUE CROSS OF CALIFORNIA**

Mr. Chairman, Mr. Thomas, Members of the subcommittee, I am Leonard D. Schaeffer, Chairman and CEO of Blue Cross of California and Chair of the National Institute for Health Care Management. I appreciate this opportunity to testify on health care reform and to assess the structure of the President's plan, the Chafee/Thomas plan, and the Cooper/Grandy managed competition bill.

Blue Cross of California has been and continues to be a strong supporter of reforming the health care system. Our positions on health reform are based on the following core beliefs:

- All Californians should have access to a choice of affordable health care services through private, innovative managed health care plans.
- Health care is a locally delivered and locally consumed service which is best administered at the local level.
- Private health plans, employers, consumers, providers and government must meet their respective responsibilities in order to achieve the goal of affordable health care alternatives for all Californians.

Congress is confronted with enormously difficult decisions on health reform. The challenge is to develop a plan that addresses the objectives of reform and that can actually be implemented in a pragmatic manner that works in states and communities throughout the nation. Because of my twenty year experience in government and private health care organizations, including service as Administrator of the Health Care Financing Organization, I recognize that the pitfalls of reform reside in its implementation.

In California, I believe we have a model of health care reform that is the result of policy makers and the private sector working together to solve public policy issues. California's approach is successful because it relies on:

- A voluntary alliance and insurance reform to increase competition in a predominately managed care market;
- Considers the state's fragile economy; and
- Does not resort to regulatory price control such as premium caps.

Concerns with Mandatory, Exclusive Alliances

The President's proposal requires mandatory and exclusive "regional Health alliances" -- a structure which presents the greatest obstacle to implementation. The plan would force all individuals and employers of fewer than a 5,000 employees into a single, quasi-governmental regional alliance that will be the exclusive purchaser of nearly all health benefits in the community.

This means that hundreds of billions of dollars will be channeled through these new, untested entities, instead of flowing directly from employers to health plans. In California, for example, about \$80 billion would be controlled through such an alliance. This unnecessarily duplicates the pooling mechanisms that are already provided by large managed care plans like Blue Cross of California, which currently pools more than one million small groups and individuals. The negative consequences of alliances arise from a number of interrelated factors.

New bureaucratic layer. The alliance is a new quasi-governmental entity inserted between employers (who pay most of the cost) and health benefit plans. Its functions duplicate and add to those of existing health care entities. For instance, alliances are required to:

- locate and identify all citizens, which means obtaining and continually updating home and work addresses;
- collect premium dollars for each enrollee from appropriate sources-- employer, employee, government and private citizens
- manage general enrollment and record appropriate AHP for each citizen; and
- disperse funds to appropriate AHPs.

AHPs, likewise, must conduct nearly the same activities -- locate, number and account for each member, manage enrollment, and collect and record premium. Even in a restructured market, both entities will do marketing, dispute resolution, eligibility enforcement, file processing and a host of other duplicative administrative functions. Not surprisingly, Lewin-VHI estimates that alliances will increase administrative costs by \$5 billion. Since the alliances are monopolies and not subject to market forces, these administrative costs will undoubtedly grow.

Loss of employer innovation. Forcing large employers to buy through an alliance eliminates one of the key sources of continuing innovation in the health system: informed employer and bargaining unit purchasers design and aggressively managing their health benefit plans.

Loss of accountability. Health alliances diffuse the accountability of cost quality and service, which will result in poorer outcomes and higher costs. It will inevitably politicize the decision making process.

The problems with the alliances are especially troublesome since they are not necessary to achieve the objectives of reform. Alliances are one possible mechanism to achieve certain objectives, but alternatives exist to fulfill those same objectives more efficiently and effectively. Attachment A is an executive summary of BCC's review of alliance issues, options and alternative means to fulfill the functions performed by alliances.

The key point is that it is not necessary to funnel hundreds of billions of dollars through these new bureaucracies in order to meet government reform objectives: market regulation, cross-subsidies for low income individuals, risk adjustment, and even enforcement of premium caps should the Congress decide to take this step. While we may disagree on some of these measures, such as premium caps (as noted below), such policies do not require an alliance-- better alternatives exist to implement such plans. States should be accorded significant flexibility to design structures that achieve federal reform objectives.

Even as the federal debate moves forward, health care financing and delivery systems are evolving in different ways across the country to expand access and control costs. States are already proceeding with health care reforms that meet their unique situations. California, for example, has already developed a market based on increasingly competitive managed care plans: 75 percent of Californians are covered under managed care plans; nearly 34 percent are enrolled in health maintenance organizations.

In this evolving marketplace, Blue Cross of California believes that we have a responsibility to solve problems of access and costs now. In the communities it serves, BCC has built on the strengths of this market-based system to increase access to health care for all Californians. Attachment B provides an overview of the BCC initiatives that are designed to meet these needs, including a new Guaranteed Coverage Program for uninsured individuals.

The California Model: Voluntary Alliances and Insurance Reform

California serves as a model for regulatory action as well. In 1992, the state took a significant step to broaden access to insurance coverage for small employers. The private sector worked extensively with the California legislature in the development of these small group reforms. Assembly Bill 1672 provided for small group reform measures that require all carriers serving the small group market to:

- guarantee issue and renewal to employer groups with five to 50 employees (declining to groups of three by 1995);
- implement rate bands, compressing to +/- 10 percent by 1996;
- limit pre-existing condition exclusions to six months; and
- disclose all small group products sold by a carrier to all small groups.

These reforms were implemented in 1993. As part of this reform, the state also established a voluntary state-administered purchasing pool for small employers. The statewide purchasing pool, the Health Insurance Plan of California (HIPC), represents a working model of a voluntary health alliance. It offers managed care health plans to small employers at affordable prices on a voluntary basis-- they can join the HIPC or purchase health benefits directly from a health plan.

The HIPC was implemented in July 1993, and offers very competitive rates. As of December 1, 1993, employer groups (32,587 members) were enrolled through the alliance. HIPC officials predict at least 250,000 members within the first two years. About 22 percent of HIPC employers were previously uninsured; the rate for BCC's private purchasing pool is slightly higher: 24 percent of new groups are previously uninsured.

The voluntary alliance in its current configuration is expanding access to affordable coverage. However, some state officials are concerned about the voluntary design, and reportedly believe that a mandatory alliance would produce greater "savings." Given the lack of any valid information on the "preferred" alternative, it is difficult to determine how the state officials have reached this conclusion.

A voluntary alliance such as California's retains a role for employers that is essential if they are expected to pay a substantial portion of the bill. In addition, the HIPC's administration costs are low because they are funded by user fees. This alliance design forces health plan and the alliances to compete with each other to serve consumers more effectively.

As we assess the health care plans under consideration, Blue Cross of California concludes that the President's alliance structure is neither desirable nor feasible. While the President deserves enormous credit for putting health reform on the national agenda, his alliance structure is simply unworkable, unnecessary, and should be modified.

Representative Cooper's bill provides for smaller alliances with a somewhat less regulatory role, but it still mandates one exclusive alliance in each community for all employers of fewer than 100 employees. These structures should be voluntary and competitive to ensure that they are responsive to consumers.

The Chafee/Thomas structure of voluntary alliances comes closest to the California model -- a working model with measurable results. As you develop health reform, we urge you to adopt that alliance structure.

California's fragile economy

California has certain features and problems in its economy and health system that shape our views on reform and merit special consideration in the policy debate.

- California is struggling to emerge from a severe recession in which 800,000 jobs were lost; 150,000 in the aerospace industry alone.
- An estimated 6 million Californians were uninsured in 1992 -- 19.3 percent of the population under the age of 65, which is substantially higher than the national rate of 14.7 percent. Eighty-seven percent of the uninsured are employed or dependents of employed persons.
- The California economy largely consists of small businesses, part-time and seasonal workers; growth in the economy will be driven by this small business sector, which complicates the provision of employment-based health coverage.
- California accounts for about 50 percent of all undocumented persons in the U.S. -- nearly two million people. A 1992 study of Los Angeles estimated the net cost of providing care to undocumented persons to be \$159 million, not including federal or state contributions.

California's recession has serious economic effects on individuals, businesses, and government. We urge you to develop a reform plan that can be implemented in a manner that reflects the economic realities of the State. Needless to say, a year of riots, fires, and a major earthquake has only exacerbated California's attempts to recover.

BCC supports universal coverage which may necessitate some form of employer mandate. However, the economic climate in California raises the concern that *immediate* implementation of an employer mandate could adversely affect the state. A recent study by Lewin-VHI estimated the impact of implementing the President's plan in California. The study:¹

- estimated net increases in cost of about \$4.5 billion in the year 1997 for California's employers;
- projected a loss of about 58,500 jobs in the first year of implementation, rising to 83,500 by year eight; and
- concluded that "implementation of the health reform produces a mild recession in the California economy," and "[T]he simulation shows no sign of a recovery even eight years after implementation."

Regulatory premium caps

Global budgets and premium caps are arbitrary limits that do not reflect the cost of and demand for care. Such limits have not worked in the past, and will not work today. Unfortunately, to the extent that they do temporarily limit spending below levels dictated by market pressures, they will reduce access and services in a manner that will be unacceptable to most Americans.

The combination of insurance reforms and voluntary alliances that we have enacted in California sets up a framework for a more competitive health care market. We urge you to allow that market to continue working, without resorting to arbitrary premium caps.

Blue Cross of California is pleased to continue to work with the members and staff of the Subcommittee and the California delegation as you develop and assess health care reform proposals. I thank you again for the opportunity to testify, and would be pleased to answer any questions.

Attachments

¹Lewin-VHI, Inc. and the UCLA Business Forecasting Project. Potential Financial and Economic Impacts of Health Reform in California. Prepared for Blue Cross of California, November 10, 1993.

ALLIANCE FUNCTIONS AND OPTIONS

Introduction

The Administration is trying to address a range of problems and objectives through exclusive, mandatory alliances. A number of alliance functions are proposed that are expected to achieve the goals of health care reform. A review of these functions suggests that alternatives exist to achieve the same goals. This paper reviews the functions, provides comments, and explores alternative mechanisms.

Functions

- (A) Function: vehicle to make products available to the small group market with lower marketing costs
Comments/alternatives:
- (1) Insurance reform and a voluntary alliance for small employers meets this need.
 - (2) The competition that results among alliance health plans and health plans outside the alliance keeps everyone's overhead costs low.
- (B) Function: vehicle to enforce insurance product and pricing rules
Comments/alternatives:
- (1) This is a necessary function;
 - (2) However, enforcing product/pricing rules can continue to be performed as a state regulatory function (e.g. California's A.B. 1672)
- (C) Function: vehicle to "manage competition" among plans
Comments/alternatives:
- (1) The Jackson Hole group term "managed competition" is a confusing concept. Competition in all markets, including health care, should occur within a set of ground rules to ensure a level playing field.
 - (2) Market competition that controls cost does not require an alliance:
 - (a) Assuring proper marketplace conduct is a standard regulatory function.
 - (b) There may be disagreement on how much regulation is desirable, but a single health alliance is not needed to enforce Congress' decision regarding the degree of marketplace regulation and competition required.
 - (c) A state regulatory agency could be empowered to oversee the market:
 - (1) It can require annual open enrollment;
 - (2) It can review plan premium bids if the Congress determines that to be necessary;
 - (3) It can screen out high price and/or low quality plans;
 - (4) It can collect and provide to consumers comparative information on health plan prices and quality; and
 - (5) It can regulate marketing to the extent that the Congress decides that is necessary.
 - (3) An alliance is not necessary to serve as an intermediary for all funds in the system to accomplish these functions.
- (D) Function: vehicle to manage budget and premium caps
Comments/alternatives:
- (1) Most economists believe price controls are not effective.
 - (2) However, if Congress decides to use price controls, an alliance is not needed;
 - (3) State agencies or commissions can regulate premiums within a national process. The Maryland Commission is an example of a state agency regulating provider rates.

- (E) Function: vehicle to manage some of the cross subsidies in health reform -- this is one of the most difficult areas to address, but it is preferable to identify such cross-subsidies up front.

Comments/alternatives:

- (1) For example, Medicaid would continue to underpay, and Federal subsidies for health reform would be capped. The impact would be further underpayment for the low income, especially if the economy declines.
- (2) The Administration proposes the alliance as the vehicle to implicitly shift and subsidize these costs.
- (3) The alliance becomes an entity that determines income eligibility for the low income (other than cash assistance recipients).
- (4) Government programs should pay their fair share, but that has not been the precedent.
- (5) Given that fact, implicit subsidies should not be imposed on health plans and other payors within an alliance. The subsidy should be made explicit instead through assessments on health plans not serving the poor.
- (6) Government agencies, not an alliance, should be responsible for any income testing under the plan.

- (F) Function: vehicle to manage risk selection among health plans through a "risk adjuster"

Comments/alternatives:

- (1) Strong insurance reforms and rating requirements eliminate the need for risk adjusters.
- (2) If Congress decides that risk adjusters are required, and some risk adjustment system is made available, the state can manage the risk adjusters among health plans outside an alliance just as they do within an alliance.

Conclusion

If Congress concludes that the foregoing functions of exclusive mandatory alliances are necessary, alternatives exist to perform these same functions. Alternatives that build on existing state structures may actually achieve the Administration's health care reform goals more quickly. Finally, such alternatives might be the bridge toward reform for some moderates and conservatives that have concerns about exclusive, mandatory alliances.

ALLIANCE FUNCTIONS AND ALTERNATIVES

FEATURE/FUNCTION	COMMENTS/ALTERNATIVES
Offer products to small group market	Insurance reform and voluntary alliance can meet this need
Enforce insurance product, pricing rules	State regulatory function
Manage competition among plans	Degree of regulation required is an issue; but whatever requirements are enacted can be enforced as state regulatory function (i.e., annual open enrollment, premium reviews, screening out plans, collect and disseminate information, regulation of marketing)
Manage global budget and premium caps	Necessity of price controls is an issue; but if enacted, can be enforced at premium level by state commission
Manage cross subsidies	Degree of cross subsidies is an issue; but whatever decided, make explicit assessments on payors/health plans
Manage risk selection, risk adjusters	Necessity of risk adjustment at issue if insurance reform enacted; but whatever decided, state can make risk adjustments among plans without alliance
Serve as vehicle to include Medicaid, other low income in private health plans; and potential vehicle for Medicare	Federal or state reform could require all private health plans to serve Medicaid and Medicare populations as condition of serving private market
Administer income testing for low income individuals	State agency function
Serve as vehicle for covering part-time, part-year, seasonal workers	State program should fulfill these functions

BLUE CROSS OF CALIFORNIA INITIATIVES TO INCREASE ACCESS TO AFFORDABLE CARE

Blue Cross of California believes that we have a responsibility to take action now to increase access to health care for Californians. After examining the composition of the uninsured in California, BCC developed a number of innovative programs to target underserved populations, many in collaboration with local organizations and state agencies; six of the initiatives are summarized below.

- **Small group access:** BCC insures over one million members who work (or are dependents of workers) for small businesses with fewer than fifty employees. The Small Group Access Program was created in 1990. It does not limit participation based on industry (blacklisting) or geographical location (redlining). The program combines high risk groups, normally unable to obtain insurance, with standard groups in order to spread the health care risk throughout the whole pool.
- **The medically uninsurable:** Individuals once deemed "medically uninsurable" can now obtain state-subsidized insurance through the BCC-administered MRMIP (Major Risk Medical Insurance Program). As of January 1994, the program served 15,521 individuals. Nearly 70% of the enrollees choose BCC as their carrier. BCC assumes full underwriting risk. This arrangement brings the benefits of risk management to disadvantaged populations.
- **Uninsured individuals:** BCC announced earlier this month a new Guaranteed Coverage Program for all uninsured individuals. The program will cover 100 percent of all uninsured applicants by placing them into one of three levels of coverage based on underwriting guidelines. The new program is effective March 1, 1994.
- **Uninsured children:** BCC addresses the needs of uninsured children through two different programs.
 - One program, CaliforniaKids, a collaborative effort between BCC and community organizations, provide primary, outpatient medical care to children from uninsured, low-income families.
 - BCC also administers and participates in the state's Access for Infants and Mothers (AIM) program which subsidizes private insurance for poor, working pregnant women and their newborns. As of December 1993, the AIM program served 14,610 working uninsured women and 7900 infants. BCC recently donated \$1 million to AIM to assure the continued enrollment of pregnant women.
- **Medicaid:** BCC was selected to participate in the new Geographic Managed Care Program in Sacramento which seeks to enroll Medi-Cal beneficiaries in managed care plans. It is estimated that 50,000 to 100,000 beneficiaries will choose BCC
- **Rural access:** BCC is a California Public Employers Retirement System (CalPERS) health plan. BCC was chosen, in part, because it has implemented an outreach strategy to offer its HMO, CaliforniaCare, to residents in 16 rural counties.

Mr. McDERMOTT. Thank you. I hope you know that your full statement will appear in the record. So anything you didn't get to say or you skipped over, the full statement will be there.

Dr. Rice, is it your view that either the Cooper or the Chafee bill provides universal coverage? Could you elaborate on that?

Mr. RICE. Well, I definitely don't think that the Cooper bill provides universal coverage. It doesn't mandate it. I don't think that the premium subsidies will be sufficient to get universal coverage.

The Thomas-Chafee bill mandates that there be universal coverage if specific Medicare and Medicaid savings are met. There are two things that I am concerned about; one, whether we are going to be meeting those Medicare and Medicaid savings. If we don't, then they are going to have to push back the implementation of universal coverage. It could conceivably be pushed back indefinitely. The second thing is I am concerned about the individual mandate, whether the subsidies are going to be large enough to make people afford it. Even if the Medicare and Medicaid savings are met, it may be that the out-of-pocket cost toward premiums will be so onerous that people will be forced to pay for this in money that they just can't afford to pay. So I am concerned that there might not be universal coverage or, if there is universal coverage, it will just cost people too much of their own salary.

Mr. McDERMOTT. As I read the Cooper bill, it would actually perhaps artificially increase the cost for small employers because they have to obtain their insurance through a HPPC where they are rolled into coverage with Medicaid and other uninsured people. Is that your understanding?

It seemed to me that it would make employers less likely to cover their people if they have to go into a pool where they meet the Medicaid population and the uninsured.

Mr. RICE. I think that that is a possibility. It depends on what pool the small business will be in under that scenario versus where they are now, but under that scenario, they will be lumped with other people that are currently not being lumped, the people who are currently on Medicaid, and the uninsured. So it may be an unhealthier risk pool. It may raise premiums that may make it harder for people to afford it. It may make it harder for businesses to offer health care coverage.

So I think that by having only a subgroup of the population, rather than everyone in the health alliance, as you could get an unhealthy mix, as you say, and, therefore, make health care coverage through the health alliances more expensive.

Mr. McDERMOTT. Mr. Steger, I have a question of you, and that is: Do you think a payroll tax is better than the President's payment mechanism? Let's just theoretically talk about it. Suppose you got rid of the health care premium and you went to a payroll tax.

Mr. STEGER. Right.

Mr. McDERMOTT. Less job losses? More job losses?

Mr. STEGER. The difference, of course, is, among other things, that the President's plan now is a graduated, if you will, tax or payment. In other words, it starts so high, and on larger companies, 7.9, it goes down, which, of course, the payroll tax would be the same. So that certainly is one difference.

I would expect that the inherent subsidy, if you will, everything else being equal, it should mean job losses should be less. The problem with it, however, is that if the amounts of money raised by the 3.5 percent, by the subsidy at the lowest levels, is not enough, then the way that the plan cycles, it cycles and comes back, and the first place it comes to is employers. Right now, as least as I understand it, the 3.5 percent can then be raised, if need be, to be able to get the extra funds.

That is a complicated answer, but I would just say that I think the President actually did with the Clinton plan take into account the fact that this graduated, if you will, tax or payment would mean for less job losses, and I just hope that our results may indicate just along those lines.

Mr. McDERMOTT. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. We have 5 minutes to go on a vote, and I am torn between asking questions or missing a vote, and it disturbs me a lot. I don't want to miss the vote, and I don't want to miss the questions.

Would you folks give us 7 minutes to run over and run back?

Mr. McDERMOTT. We would appreciate it if you would be willing to wait because we do have other questions. I have some others as well. So we will be right back.

The meeting stands in recess.

[Recess.]

Mr. McDERMOTT. The committee will come back to order.

I apologize for health care reform from the back of the galloping horse. Mr. Thomas will inquire.

Mr. THOMAS. Thank you very much, Mr. Chairman.

I will thank Dr. McCaughey while she is talking to our other member in terms of the particulars that she is providing us with, but that we are looking for alternatives beyond the Clinton plan because I think, clearly, for all the reasons that, Doctor, you have outlined, the Clinton plan is deficient in the alliances. I think the CBO report finally now clearly indicates in chapter 5 that some of these new and novel structures, even if they are not pernicious, given the controlling structure that is there, make it probably impossible for them to perform in the manner that they are anticipated to perform, and if they don't, the system doesn't work.

So I hope we are going to conclude phase 1 of explaining why the Clinton plan doesn't work because I think the vast majority on this panel believe that in terms of the way the alliances are structured, and we are looking for viable alternatives.

Dr. Rice, did you write your analysis prior to the CBO? I assume you did.

Mr. RICE. Yes, I wrote it last week.

Mr. THOMAS. I think you misunderstand partially the mandate structure in Chafee-Thomas, and that is that if the money isn't found, the mandate still goes into effect, but it does not go into effect for those folk who have not been brought under the subsidy cap, but would if, in fact, the moneys were there.

Frankly, I think one of the interesting points out of the CBO study is that if you compare the President's ramping down of Medicare within the time frame that he has indicated he wants it to come about, the glideslope of the Chafee-Thomas bill from 12 to 7

percent over a 10-year period is really not the Procrustean bed, I think, that some folks say it is. But that if, in fact, we did it, the added incentive of buying down that area, I think, creates a nice synergism in terms of keeping us honest.

One of the reasons we have put that in there was when the First Lady was in front of us on the first day of our hearings, I said, "Given the benefits up front, you hope the payment comes later. Could we tie it together in some way, so that you would create an incentive for Congress to provide the payment for those benefits?" In essence, she said no.

So what we have done in this bill is tie the two together. If you really want the benefits for those folks, then let's make sure we make the changes.

Your concern about the adverse selection in the purchasing cooperatives from a relative point of view, I think would be very real under the alliances because they have got to have a risk-adjustment mechanism, and there just ain't no way to build one.

In Cooper-Grandy, because they are mandatory and especially because they put an employer cutoff number, I think it is partially true as well, but I have difficulties seeing that argument carried over to our structure which is a voluntary purchasing system with multiple cooperatives within a given area. The private sector with the insurance reforms and the antitrust reforms, organizing their own groups, Chamber of Commerce, Farm Bureau, or whatever, so that, if, in fact, a particular purchasing cooperative does wind up with adverse selection, it either fades away and they move to others or they redo the way in which they are doing business. There is a lot more dynamism in the structure that we are offering than most of the others that mandate or make it rigid.

Is that a fair comeback to your criticism?

Mr. RICE. Sure. I guess one concern I would have on the last point would be whether these purchasing alliances, since they can compete with each other, might try to compete on the basis of getting the better risks.

Mr. THOMAS. That is a concern, and in the tradeoff between price and package, that is why I opted for a relatively defined benefit package, so that basic structure would be available and you would have to look at it without being able to structure a package under a dollar amount that would, in fact, enhance that risk selection.

We aren't going to be perfect, but I think we minimize the down side of the unknown far greater than virtually any other plan, and perhaps Mr. Schaeffer would like to talk about what has happened under the California voluntary purchasing and whether or not they have seen a massive adverse risk selection structure occurring so far in California.

Mr. SCHAEFFER. Mr. Thomas, I think you make an important point. In California and in your bill and in some other bills, it is important to look at the health alliance in conjunction with the insurance reform changes.

In California, all of the discriminatory practices, redlining, black-listing, cherrypicking, job lock, all those practices are illegal. The law requires guaranteed issue, guaranteed renewability, 20-percent rate bands going down to 10-percent rate bands, and limits on pre-existing condition provisions. If you take that and you put it next

to a voluntary alliance, many of these distortions that we worry about today just aren't there. In California, I can tell you, there are very few ways you can do risk selection as opposed to having to manage the cost of care.

Mr. THOMAS. It is certainly far less than the creative area today and, more importantly, probably not enough to make it worth your while in the margin of difference versus a good, honest product, honestly presented, and that is the key.

I am looking forward to increased information from the experience in California. We have only been on it, what, since July—

Mr. SCHAEFFER. Right.

Mr. THOMAS [continuing]. Of last year, but I am very pleased with the information we are getting now because it is some of the first factual stuff we have had to knock down some of the myths that continue to be presented about what the brave new world is going to look like, but I agree with you completely. Don't read pieces of the bill, read the whole bill, and with those insurance reforms and the antitrust reforms, it creates a synergism in the industry which I think keeps everybody honest and doesn't have government pick winners, as those mandated structures do.

Frankly, if these new structures are destined to rule the day and they do it in a free, competitive structure, more power to them. I just don't want to give them an unfair advantage.

Mr. SCHAEFFER. Absolutely. If they can do a better job than we can, then they ought to win. The irony is that, although some insurers have left the State because they don't want to compete under the new rules, those that have remained, I think have done better. Blue Cross has had a great period since the voluntary alliance went in, and so has the voluntary alliance. So much more coverage has been made available.

As I mentioned in my testimony, 24 percent of the coverage we are selling is going to groups who were previously uninsured. So it is working. We are reaching out, as is the voluntary alliance.

Mr. THOMAS. Mr. Chairman, let me just close by saying that had we locked in the purchasing pattern 20 years ago, managed care would not have been in the law, and that the last thing I want to do is lock in any one particular structure and let the private sector with fair rules, honestly supervised, continue to be creative in offering us new patterns that, in fact, will probably drive the price down in new and creative ways that we don't know about today.

Thank you, Mr. Chairman.

Mr. McDERMOTT. Mrs. Johnson will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I do appreciate, Mr. Schaeffer, your comments. I have pulled out of the Chafee-Thomas bill the voluntary purchasing cooperative piece, so that it can be examined by everyone, so the issue can be raised about diversity in the market and its importance to coverage, to quality in the future, to being able to meet our citizens' needs. So your testimony has been very useful, and I particularly commend you on opening your plan to all the uninsured on a guaranteed coverage basis.

I believe that a lot of others are going to begin to notice that that is a very good market for them, and you may actually solve your problem before we do.

Dr. McCaughey, you have raised a very, very serious challenge to the President's health care reform proposal, and I mention it because I think that is not the only reform proposal that could, as we debate this issue, fall into the same trap.

You make the claim that you will not be able to buy a doctor's services outside of your plan. Now, that is a really big problem. There is a lot of judgment involved in medicine. It is as much an art as it is a science.

Ms. McCAUGHEY. That is right.

Mrs. JOHNSON. Acute pain may mean bed rest to one doctor and an operative procedure to the other.

In reading the President's staff's response to your accusation in the New York Times recently, I was interested that they claim unequivocally that people could decide to pay for care out of their own pocket. Would you comment on this issue?

Ms. McCAUGHEY. Yes, because I think it really goes right to the heart of the matter, and here is what happens. You have to buy one of the low budget health plans offered by the regional alliance where you live. That is the first factor. Paying the mandatory premium and then going outside the system to buy a plan you think is better is not permitted.

Second, when you go see the doctor, you have to show him your health security card and prove that you are enrolled in a plan. If not, he must begin the procedure to enroll you in a plan right then, and if he is going to treat you for basic illnesses and offer the kind of basic medical services that are listed in this bill, he has to be paid by the plan, not by you, except for a fixed copayment. In other words, if he takes payment directly from you, rather than filling out the form and sending it into the alliance for payment, it is a \$10,000 fine for each offense.

That goes for doctors inside HMOs and doctors practicing on a fee-for-service basis, and it doesn't matter what kind of plan you are in. If you buy a fee-for-service policy, your doctor still has to fill out that form and get paid by the plan, not directly by you. You can't pay him extra.

Balanced billing and direct billing are prohibited. It is on page 236 of the plan. It is also in next week's New Republic magazine.

It is also important to note that he must report your visit according to the requirements of Title V establishing a national databank. Now, this leads to two really critical issues. One is that it is going to be very hard to go outside your prepaid plan and find a doctor who will serve you on a PPO or fee-for-service basis if you don't like the doctor in your health plan or if your health plan gatekeeper doesn't want to let you see a specialist. Why? Because fee-for-service insurance is going to be almost impossible to buy. So very few doctors will be practicing outside these prepaid plans, outside of contractors with HMOs.

Why will fee-for-service insurance be so hard to buy, and why will so few doctors be out there willing to see you on that basis? Well, there are three reasons.

First, the regional alliances cannot permit the average premium paid in the region to exceed the ceilings imposed by the National Health . There is a whole series of renegotiations that occur on

pages 1000 to 1005 in which the plans must voluntarily reduce their premiums each year in order to do business in the region.

Second, the regional alliance officials are empowered to exclude any plan that costs 20 percent more than any of the other health plans, 20 percent more than the average weighted plan in the region. It is kind of like passing a law that you can't buy a car that cost 20 percent more than the average car.

They will have to apply that 20 percent rule virtually all the time which means that fee-for-service insurance which is always more expensive than prepaid or managed care, even when there is a large deductible and copayment, will be eliminated.

The bill says that, in general, each regional alliance shall include among its health plans one fee-for-service or choose-your-own-doctor plan, but it is not always true because there are these other rules that will make it virtually impossible for regional alliance officials to do it. They will only be able to offer a plan that costs 20 percent more than the average plan if other plans come in way under the ceiling imposed by the National Health , and that is highly unlikely because the increase in the price of the plans per year is pegged to the consumer price index, and you know that the current annual increases in medical spending are rising much faster than that.

Third, because the regional alliance officials are empowered to set the fees for doctors per clinical visit or treatment and to limit how much are paid to doctors in each specialty per year, doctors are not going to be able to focus on that basis. Perspective budgeting means that their salaries are going to drop precipitously toward the end of the year, as they do in Canada when the budget in the region for pulmonologists or cardiologists runs out of money.

So is it going to be possible for a patient to go outside his prepaid plan when he has a heart problem and the doctor recommends rest and he thinks he may need angioplasty? In practice, it is highly unlikely that he will be able to do that, and he certainly won't be able to go to any doctor and pay any price for any service.

Mrs. JOHNSON. Unfortunately, so that my other colleagues can finish, after this vote, we have a 5-minute vote. So we do want to have the panel have the right to go on its way after this questioning. So thank you very much, and I look forward to your additional articles and thank the panel for their good input.

Mr. McDERMOTT. Mr. McCreary will inquire.

Mr. McCREARY. Thank you, Mr. Chairman.

Mr. Helms, I was interested in your testimony, your oral presentation to the committee, in which you said that in an effort to control costs, medical savings accounts might do some good, but the most important thing would be to cap the tax deductibility and tax exclusion for insurance products.

Both of those things have to do with getting the individual back in the ball game of controlling cost, putting some of the burden for controlling cost in the system on the individual. Is that correct?

Mr. HELMS. That is right. There is a large body of literature on the role that the tax treatment of health insurance has played since World War II when it started. The tax exclusion of health insurance gives people incentives to bargain for more and more health insurance and to include more benefits into the policy be-

cause it is worth more to people to get things that they know they are going to spend money on into the health plan, which is tax-free, than to get the wages which are taxable.

Mr. McCRERY. Right. Absent getting back into the health care system some of these personal incentives to control cost, about the only thing we can do is bureaucratically impose cost controls. Wouldn't that be the conclusion that you would reach?

Mr. HELMS. Yes, I tried to say in my testimony that if you don't have anything to change consumer behavior on the demand side, then you put all your eggs in the basket of controls.

Mr. McCRERY. Right, and that is essentially where the Clinton plan goes and Mr. McDermott goes with his single-payer plan.

Mr. HELMS. Yes, the administration would argue that they have put their eggs in the basket of competition and so will not need the controls. But my argument is that their version of competition will not work so that they will be forced to go to controls.

Mr. McCRERY. I agree.

I have handed you a slip of paper with just a brief synopsis of my health care plan that I am currently drafting with the legislative counsel, and in that plan, I combine the two things that you mentioned, medical savings accounts and a tax cap. I also limit the tax-favored treatment of insurance products in the Tax Code to high-deductible products coupled with medical savings accounts or a managed car plan, thereby denying a deduction for first-dollar coverage insurance and for low-deductible insurance. In your opinion, is that a powerful combination to get individuals back in the ball game?

Mr. HELMS. Very much so, and let me say I was only aware of your efforts when you gave this to me. From my glance at it, your plan is very close to a plan called Responsible National Health Insurance that was authored by Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff that AEI published in 1992. It seems to have a lot of the same features that were written in to that plan. In addition, your plan looks to be very close to the simple tax cap approach that we pushed early on in the Reagan administration when I was at HHS under Secretary Schweiker.

We argued at that time that where you set the cap was not so important as sending a message that this is not an open-ended game anymore, that way you give people incentives to start looking around to produce what we would call private cost containment as opposed to public cost containment. I look forward to finding out more about your proposal.

Mr. McCRERY. Thank you.

Mr. Steger, you wanted to comment?

Mr. STEGER. Yes. It is also the kind of plan that I think certainly would not have the million job losses of the employer mandate, but, also, given what you have talked about with the tax angle, I think it would probably increase demand in the short run, too. So you probably can have a million-plus the other way. It is attractive at least from that angle.

Mr. McCRERY. Thank you.

The one question that we don't have time to get into, but I would like to perhaps hear your thoughts on it, would be whether to

couple this with an individual mandate. If you can respond in 30 seconds, that would be great.

Mr. HELMS. Oh, you actually want me to respond?

Mr. MCCRERY. Well, if you want to, but you may want to give it some more thought.

Mr. HELMS. I just attended a major conference at Princetown University looking at employer versus individual mandates. Several economists argued that you could get any effect from either mandate depending on how you structured them. But at least one economist Mark Pauly of the University of Pennsylvania, argued that the individual mandates were much more effective in terms of being able to target on the behavioral effects that you want. Therefore, I am more in favor of the individual mandate than an employer mandate.

Mr. MCCRERY. I am trying to work an individual mandate into my plan. The problem with one, of course, is how you pay for very low-income individuals on whom you place the mandate—and they have no way to pay for the coverage.

Mr. HELMS. Correct. It is a difficult issue, and I do not want to say it is an easy thing to do, but between the two, I favor the individual mandate.

Mr. MCCRERY. If I can find a good way to do it, though, and finance it, I am going to include that in my bill.

Ms. McCAughey? Yes.

Ms. McCAUGHEY. May I offer one comment that is not in my testimony, but may be very helpful to everyone, and that is New York City has just realized how unsuccessful it is in our city to try to enroll the urban poor in HMOs as a way of keeping them from using emergency rooms for basic medical care.

What we have found ends up happening is that the government entity, whatever it is, pays the premium to the HMO, but because of cultural differences, the people who need that care, instead of going to the HMO and meeting a doctor's appointment, still report to the emergency room at 2 or 3 in the morning, whatever day they are free, whatever time they need care, and so what ends up happening is that the hospital provides the care. Often these people lie about—I shouldn't say lie—evade the question of who they are and whether they have any kind of coverage with a prepaid health plan in order to be able to be served in an emergency room, and then, by the time the hospital figures out who they are, the notification period with the prepaid health plan has expired or the prepaid health plan tells the hospital that the care given does not qualify, is emergency care.

So, as we discuss this concept of universal coverage and paying premiums for every single person who needs health care, we probably shouldn't forget that it may not be practical to enroll everyone in one of these prepaid plans or it may take a long time to achieve that kind of cultural transition, and in the meantime, we can't halt the payments to hospitals who care for the urban poor.

Mr. MCCRERY. Interesting.

Mr. McDERMOTT. I would comment that that sounds like we need a single-payer system, and I won't give you much time to comment on that because we only have 4 minutes to make a vote.

The committee is grateful for your testimony. We thank you for coming. The committee will be in recess. We will be back in about 10 minutes for the next panel. Thank you all very much.

[Recess.]

Chairman STARK. You have the distinction of not only being the final panel today, but the final panel for the whole issue in 1994 of health reform before the Ways and Means Committee. So I commend you. I hope it was worth the wait, and you have the chance for the very last word before we start to make sausage.

Dr. Simmons, it is good to see your back. Dr. Simmons is president of the National Leadership Coalition for Health Care Reform, and you are accompanied, I noticed, by Mark Goldberg, who is the deputy director for the Coalition. We also have Gail Shearer, who is the manager for policy analysis of Consumers Union; Pam Bailey, who is the president of the Healthcare Leadership Council; Anthony Knettel, who is the health policy director of the ERISA Industry Committee; and Dirk Van Dongen, cochairman of the Healthcare Equity Action League.

I would suggest to the witnesses that your complete statements will be included in the record in their entirety, and the chairman would ask that you summarize or expand on your testimony within the allotted time.

Henry, do you want to lead off?

STATEMENT OF HENRY E. SIMMONS, M.D., PRESIDENT, NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM; ACCOMPANIED BY MARK A. GOLDBERG, DEPUTY DIRECTOR

Dr. SIMMONS. Thanks, Mr. Chairman. I appreciate the opportunity to speak about system reform and about some of the proposals under consideration and, as you stated, on behalf of the National Leadership Coalition.

That coalition is the Nation's largest and most diverse alliance on health care issues. The coalition consists of nearly 100 organizations—65 businesses in all sorts of industries and many of the Nation's largest unions, consumer and provider groups. Taken together, these organizations include as employees or individual members about 100 million Americans.

Our coalition is absolutely nonpartisan. Our honorary cochairmen are former Presidents Carter and Ford, and our cochairmen are former Iowa Governor Bob Ray, a Republican, and former Congressman Paul Rogers, a Democrat.

We began working nearly 4 years ago to develop an effective strategy for health care reform, and it is striking to us and, frankly, heartening that virtually all of the major health reform bills in this Congress attempt to address the 8 goals that our members identified more than 2 years ago and continue to support: Improvements in quality, universal coverage, cost control, the development of organized delivery systems, insurance and malpractice reforms, and administrative simplification.

I am going to concentrate today, Mr. Chairman, on just two of those goals, universal coverage and cost control.

Our coalition believes that universal coverage is a crucial element of health reform to provide a health care safety net for every

American. Improving access to health insurance, which many of the bills before you would seek to do, is good, but it is not enough. We must insist on making sure that every American actually has coverage.

As you know, we fall well short of that ideal today. According to a recent report, the number of Americans without health coverage increased by 2.3 million between 1991 and 1992, the largest increase in the past decade.

In light of that, we urge you to report out a bill that includes both an individual mandate and an employer mandate. Why do we believe that an employer mandate makes sense? First, the overwhelming preponderance of those nonelderly Americans who have private health insurance, 88 percent, receive it through their employers or the employers of their family members, and we believe it is sensible to build on that very large base, and there is broad and strong support for that approach.

Second, a similar proportion of the uninsured, about 84 percent, are either in the work force or in families that are headed by someone who is. That means that an employer mandate would permit us to maintain and sustain the coverage now received by most of the Americans who have it and, at the same time, extend coverage to most of the Americans who do not.

Contrary to some recent reports, the health care spending crisis continues to grow worse. The Department of Commerce recently estimated that U.S. health care spending last year increased over \$100 billion, the largest 1-year increase in our history, and Commerce projects health care spending will rise at an average rate of 13.5 percent per year over the next 5 years. We can't go on that way.

We need insurance and malpractice reforms and more efficient delivery systems, yes, but we also need more. Our recommendation is that your legislation include expenditure targets and rate-setting for the fee-for-service segment of the system, to keep spending increases in bounds while organized delivery systems which would be exempted from rate schedules, are encouraged to grow.

Experience here and elsewhere has made it clear that rate-setting is an effective tool for controlling cost, and in the context of a reform strategy that also includes increased competition among health plans, it can establish, in effect, a cost ceiling for that competition.

We would caution that bills that cut the rates of growth in Medicare and Medicaid in the short term without establishing tough cost controls that operate concurrently with those cuts invite providers to shift costs to the private sector.

We would caution as well against reliance for cost constraint largely on measures designed to increase competition. We believe, as the CBO testified yesterday, that such steps, although important and useful, are not sufficient to meet America's urgent need for health care cost control.

First, the leading advocates of managed competition have acknowledged at least a third of the U.S. population lives in areas that are not populated enough to permit the creation of effective competition.

Second, time is of the essence, and even if managed competition alone would be effective over the longer run in constraining cost, and we cannot be assured of that, we believe the country needs relief in the shorter term. The Department of Commerce projections are bracing. Total health care spending is on track to double in the next 5 years.

Mr. Chairman, we look forward to working with you and your colleagues, Democrats and Republicans alike, to achieve health care reform that disciplines health care spending, that assures comprehensive health coverage, and that brings better care for all Americans.

[The prepared statement follows:]

STATEMENT OF HENRY E. SIMMONS, M.D., M.P.H., F.A.C.P.

PRESIDENT OF THE NATIONAL LEADERSHIP COALITION
FOR HEALTH CARE REFORM

I am Dr. Henry E. Simmons, president of the National Leadership Coalition for Health Care Reform. I am pleased to have this opportunity to speak with you today about health care reform and some of the proposed reform bills now under consideration. With me is Mark A. Goldberg, the deputy director of the Coalition.

The National Leadership Coalition is the nation's largest and most diverse alliance on health care issues. As the list appended to my written testimony indicates, the Coalition consists of nearly 100 organizations -- major businesses in all sorts of industries, unions, consumer groups, and associations of health care providers. Taken together, these organizations include -- as employees or individual members -- about 100 million Americans.

The Coalition is absolutely non-partisan. Our honorary co-chairmen are former Presidents Jimmy Carter and Gerald R. Ford. Our co-chairmen are former Iowa Governor Robert D. Ray, a Republican, and former Congressman (and Chairman of the Energy and Commerce Subcommittee on Health and the Environment) Paul G. Rogers. We believe, as Presidents Carter and Ford recently wrote in The Washington Post, that

the problems of our health care system do add up to a crisis -- and we need to attend to it with the urgency, and the willingness to put aside partisanship, that a real crisis warrants.

It is in that spirit, and with that sense of urgency, that we have been working with members of both parties toward the achievement of effective reform. I would like to discuss briefly what we believe the essential ingredients of effective reform are and to offer some thoughts on the alternative proposals before this Subcommittee.

The members of the National Leadership Coalition began working together nearly four years ago to develop, jointly and by consensus, an effective strategy for health care reform. The product of that effort was the plan set out in our November, 1991, report, Excellent Health Care for All Americans at a Reasonable Cost. I have appended to my written testimony an essay from the New England Journal of Medicine, in which we summarized that plan..

It is striking -- and, frankly, it is heartening -- that virtually all of the major health care reform bills in this Congress attempt to address the eight goals that our members identified more than two years ago and continue to support:

- o improvements in the quality of the health care that Americans receive;
- o universal coverage;
- o cost control;
- o encouragement of the development of organized delivery systems;
- o effective management and oversight through a public-private partnership;
- o insurance reform;
- o malpractice reform; and
- o administrative simplification.

To be sure, real differences of opinion do exist about how best to achieve these objectives -- and how fast to approach them. But as those differences are debated, here and across the country, we should recognize, and be encouraged by, how much agreement, on ends if not means, has already been achieved.

I want to concentrate, in my brief remarks here today, on two of the eight goals that I just enumerated: universal coverage and cost control.

Congress has a chance this year to make history -- to assure, for the first time, that every American, rich or poor, healthy or ill, will have comprehensive health coverage every day of his or her life. That, at its very core, is what the debate about health care reform needs to be about: how to make that dream come true, how to make that guarantee real.

The members of the Coalition believe that universal coverage is a crucial element of health care reform -- to provide a health care safety net for Americans that virtually all other industrialized nations provide for their citizens. Improving access to health insurance, which many of the bills before you would seek to do, is good, but it is not enough. We should insist on making sure that all Americans actually have coverage.

We fall well short of that ideal today. According to a recent report by the Employee Benefit Research Institute, the number of Americans without health coverage jumped between 1991 and 1992 from 36.6 million to 38.9 million -- an increase in just one year of 2.3 million and the largest increase in the past decade. These men, women, and children live every day in physical and financial peril -- literally in crisis.

The Coalition urges the Subcommittee to report out a bill that includes both an individual mandate, such as is contained in H.R. 3704, and an employer mandate. Why do we believe that an employer mandate makes sense? First, the overwhelming preponderance of those non-elderly Americans who have private health insurance -- 88 percent -- receive it through their employers or the employers of their family members. It is sensible to build on that very large base -- of coverage and of financial support for coverage.

Second, a similar proportion of the uninsured -- about 84 percent -- are either in the workforce or in families that are headed by someone who is. That means that an employer mandate would permit us to maintain and sustain the coverage now received by most of the Americans who have it -- and at the same time extend coverage to most of the Americans who do not.

For those businesses that already provide coverage to their employees, a mandate would not be so burdensome, if properly constructed, because it would require them to do what they are already doing. Of the minority of small businesses that do not provide coverage now, most have fewer than 10 employees and relatively low average wages. An employer mandate should be accompanied by measures to cushion the impact of a mandate on these firms. At present, in the absence of a level playing field, those firms that provide coverage are disadvantaged in their competition with those that do not -- first, because they have taken on this additional responsibility and cost, and, second, because the premiums they pay help to cover the costs of emergency care for employees of the firms that do not provide coverage. When all similarly situated firms have similar responsibilities, companies will compete on price, quality, and service -- not on whether they are able to avoid providing health insurance.

The support for universal coverage through a combination of mandates -- an individual mandate and an employer mandate -- is broader than is sometimes recognized. The National Leadership Coalition for Health Care Reform, as I mentioned earlier, includes nearly 100 organizations that strongly support this combination of mandates. And I want to emphasize that about 65 of these organizations are businesses. In addition, the American Hospital Association, the U.S. Chamber of Commerce, the Catholic Health Association, the Corporate Health Care Coalition all back this approach as well, although their preferences as to other aspects of health care reform may differ from the Coalition's. And, as you know, H.R. 3600 incorporates a commitment to the achievement of universal coverage through this combination of mandates.

The Coalition believes -- and I want to be very clear about this -- the assurance of universal coverage must be accompanied by tough cost control and initiatives to improve the quality of care. We support an individual mandate conjoined with an employer mandate in the context of comprehensive reform that includes these other elements. It would not be wise to extend health coverage to 39 million more Americans without making sure that we had in place strong mechanisms to keep costs contained and measures to assure that the quality of care in an expanded system improves, rather than deteriorates. We need to proceed on all these fronts at once.

Contrary to some recent reports, the health care spending crisis is continuing to get worse. The Department of Commerce recently estimated -- in a study that received little attention because it was released between Christmas and New Year's Day -- that U.S. health care spending in 1993 totaled \$942.5 billion. That's an increase from 1992 to 1993 of \$102.3 billion -- the largest one-year increase in history. And Commerce projects that health care spending will rise at an average rate of 13.5 percent per year over the next five years, doubling our health care costs.

We can't go on this way. We need insurance reforms and administrative simplification and more efficient delivery structures, yes, but we also need more. Our recommendation is that the Subcommittee report out legislation that includes expenditure targets and rate-setting for the fee-for-service segment of the health care system -- to keep spending increases in bounds while organized delivery systems, which would be explicitly exempted from rate schedules, are encouraged to grow. Experience here in the United States and elsewhere in the world has made it clear that rate-setting is an effective tool for controlling costs -- and in the context of a reform strategy that also includes increased competition among health plans, can establish in effect a cost ceiling for that competition. Over time, we can and should increase the competitiveness of health care delivery systems; in the meanwhile, we ought to make sure that costs don't continue to spiral out of any control.

We would caution that bills that cut the rates of growth in Medicare and Medicaid in the short term without establishing tough cost controls that operate concurrently with those cuts invite providers to make up for their lost revenue by raising premiums paid by businesses and other private payers. We would caution as well against reliance for cost constraint solely on measures designed to increase the competitiveness of health care markets. We believe that such steps, although important and useful, are not sufficient to meet America's urgent need for health care cost inhibition. First, as the leading academic advocates of managed competition have readily acknowledged, at least a third of the U.S. population lives in areas that are not densely enough populated to permit the creation of effective competition among multiple health plans. Second, time is of the essence. Even if managed competition alone would be effective over the longer run in constraining increases in health care spending, the country needs relief in the shorter term. The Department of Commerce projections are bracing: Total health care spending is on track to double in the next five years.

We look forward to working with you and your colleagues to achieve health care reform that disciplines health care spending and that assures comprehensive health coverage, and excellent care, for all Americans.

MEMBERS OF THE NATIONAL LEADERSHIP COALITION FOR
HEALTH CARE REFORM

Acme Steel Company
 Amalgamated Clothing & Textile Workers Union, AFL-CIO
 American Academy of Family Physicians
 American Academy of Pediatrics
 American Association of Retired Persons
 American College of Physicians
 American Federation of Teachers, AFL-CIO
 American Iron & Steel Institute
 American Nurses Association, Inc.
 American Physical Therapy Association
 American Psychological Association
 Association of Academic Health Centers
 Association of Minority Health Professional Schools
 B. C. Enterprises
 Banc One Corporation
 Bank South Corporation
 Bannon Research
 Bethlehem Steel Corporation
 Blue Diamond Growers
 Brown & Cole Stores
 Burlington Coat Factory
 Caterpillar Inc.
 Ceridian Corporation
 Christian Children's Fund
 Chrysler Corporation
 Cold Finished Steel Bar Institute
 Communication Workers of America
 CoreStates Financial Corp.
 Del Monte Foods
 Drummond Company Inc.
 Families USA Foundation
 Filter Materials
 First Interstate Bancorp
 Ford Motor Company
 Georgia-Pacific Corporation
 Giant Food Inc.
 The Great Atlantic & Pacific Tea Company, Inc.
 Gross Electric Inc.
 The Heights Group
 H. J. Heinz Co.
 Geo. A. Hormel & Company
 Hunt-Wesson Inc.
 Inland Steel Company
 INSIGHT Treatment Services, Inc.
 International Brotherhood of Electrical Workers
 International Multifoods
 International Union of Bricklayers and Allied Craftsmen
 James River Corporation
 Johnstown Corporation
 Keebler Company
 Keller Glass Company
 Lincoln Telephone & Telegraph Co.
 Lockheed Corporation
 LTV Steel Company

Lukens Inc.
 Mars, Incorporated
 Maternity Center Association
 National Association of Childbearing Centers
 National Association of State Boards of Education
 National Easter Seal Society
 National Education Association
 National Steel Corporation
 Norwest Corporation
 Olympia West Plaza, Inc.
 Pacific Gas & Electric
 PAR Associates
 Pella Corporation
 Preferred Benefits
 R. R. Donnelley & Sons Co.
 Ralphs Grocery Company
 Regis Corporation
 Rohm & Haas Company
 Safeway Inc.
 Sara Lee Corporation
 Scott Paper Co.
 Service Employees International Union, AFL-CIO
 Sokolov Strategic Alliance
 Southern California Edison Company
 Strategic Marketing Information, Inc.
 Texas Heart Institute
 Time Warner Inc.
 United Air Lines, Inc.
 United Food and Commercial Workers International Union, AFL-CIO
 United Paperworkers International Union, AFL-CIO
 United States Catholic Conference
 United Steelworkers of America, AFL-CIO
 UNUM Life Insurance Company of America
 U.S. Bancorp
 The Vons Companies, Inc.
 Westinghouse Electric Corporation
 Wheat, First Securities, Inc.
 Wheeling-Pittsburgh Steel Corp.
 The Whitman Group
 Wisconsin Public Service Corporation
 Xerox Corporation

Chairman STARK. Thank you.
Ms. Shearer.

**STATEMENT OF GAIL SHEARER, MANAGER FOR POLICY
ANALYSIS, CONSUMERS UNION**

Ms. SHEARER. Thank you, Mr. Chairman, and thank you for inviting Consumers Union to testify today on the issue of national health reform legislation.

To analyze the five proposals on the agenda today, we have created a checklist of consumer concerns in health reform. None of the five bills under consideration today, however well-intentioned they may be, comes close to meeting the needs of consumers.

I plan to focus in my oral statement on three of the issues of most concern to consumers, universality, catastrophic coverage, and comprehensive benefits.

No question is more central to the success of health care reform than the issue of universality. As long as insurance coverage is voluntary, there will continue to be horror stories of the suffering of families who are left out of the system. A recent poll found that 79 percent of those polled favored health care reform that provides guaranteed coverage for everyone.

The five bills under consideration today will not provide universal health care protection. Three of the bills, those sponsored by Representatives Michel, Johnson, and Cooper-Grandy rely on market incentives without a mandate or employer contribution to increase access to health insurance and are likely to leave millions of Americans without insurance.xxx

Two of the bills, those sponsored by Representatives Thomas and Stearns, have an individual mandate, but fail to assure universality because either subsidies for low-income families are dependent on nonguaranteed cost savings or because there is no mechanism for making insurance premiums affordable to all families.

Neither bill calls for an employer contribution. Neither limits the percent of income that must be spent on premiums. Even families with modest incomes would have to pay 100 percent of the premium cost if their employers don't contribute.

Universality is also undercut by the preexisting condition clauses in these bills. While H.R. 3652 appears to leave preexisting condition regulations to the States, the other bills allow for the possibility that people, even children who do not have continuous health care coverage, could be subject to 6- to 12-month periods of preexisting condition restrictions. It is important for everybody to understand that restricting preexisting condition limitations is not the same as eliminating them altogether.

Under these four bills, children may not get their needed asthma medicine and may end up in the emergency room. Diabetics may not get their needed insulin. People with high blood pressure may not get the medicine they need. Only a truly universal system, one that eliminates the need for people to go in and out of health insurance coverage can truly eliminate preexisting condition traps.

The promise of comprehensive benefits will be hollow if families can buy a catastrophic policy with a high deductible and be considered insured. A \$3,000 deductible does not deliver preventive care

to children, insulin to a diabetic amounting to \$2,500 or many other pressing health care needs.

If covered by only a catastrophic policy, many low- and middle-income families will not get access to comprehensive care. Instead, they will end up with an unfunded medical savings account and an insurance policy with a \$2,000 or \$4,000 deductible. Financial barriers will continue to restrict access to care.

Four of the bills under consideration today, all except for the Cooper-Grandy bill, undermine the value of health insurance coverage by allowing for catastrophic coverage to be considered health insurance coverage. Family deductibles in these four bills range from \$2,000 to \$4,000. Consumers strongly support comprehensive benefit packages. They need comprehensive benefits because the private market has incentives to exclude coverage for your most likely health care needs.

The cliché that you can't buy fire insurance when the barn is already burning applies to health insurance. Once a family needs long-term care, insulin, chemotherapy, insurance companies prefer not to take your call. Each family has its own unique health profile and its own set of health care needs.

I would like to close by modifying the popular slogan of the week regarding crime control. Three strikes and you're out. Strike one, make participation and employer contribution voluntary. Strike two, pass the buck on defining benefits to an outside commission. Strike three, encourage catastrophic policies with a \$3,000 deductible. Any of these crucial mistakes will totally undermine health care reform and result in gaps in coverage and continuing suffering, lack of needed health care, and financial barriers to care.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF GAIL SHEARER CONSUMERS UNION

Thank you for inviting Consumers Union¹ to testify today on the issue of comprehensive benefits in national health reform legislation. Members of this Subcommittee have worked for health reform for many years; I don't think you need convincing about the fact that there truly is a health care crisis in this country. In conjunction with the Campaign for Health Security, we have recently released reports that show how the health care crisis affects people at both ends of the age spectrum -- seniors and children. Despite Medicare coverage, seniors suffer in the health care system because they can't afford prescriptions or the high cost of long-term care. They have restricted choice of doctors when low Medicare reimbursement rates decrease doctors' willingness to accept them as patients. They are forced to use their limited funds to pay their hospital deductible and their 20 percent copayments. They are victimized by a private long-term care insurance market that puts the profits of the insurance companies above the needs of policyholders.

Americans' children, and their parents, know there's a health care crisis. When 450,000 pregnant women have no health insurance, inadequate prenatal care -- and low birth-weight babies with a variety of ailments -- are inevitable. Insurance policies regularly exclude the all-important well-baby and well-child check-ups. They rarely cover immunizations such as measles shots that can prevent serious chronic illness. Pre-existing condition exclusions and outright denial of coverage often leave children with serious illnesses uninsured. Children in need of chronic care including rehabilitation, such as children with cerebral palsy or children recovering from brain tumors, too often find that their needs are unmet. As families struggle to work their way out of poverty, they often find that they lose their Medicaid eligibility and the health care that their children so desperately need.

The nation urgently needs health care reform. But we do not believe that reform that is voluntary will come close to providing health care security for all. Nor do we believe that the nation will be able to pay the bill for health reform unless employers are required to make a substantial contribution toward the cost. Furthermore, legislation that counts you as insured if your family faces a \$4000 deductible is not the type of reform that consumers need.

We believe that health care reform must offer:

universal, quality health care with comprehensive benefits for all U.S. residents -- regardless of age, income, employment status or health status;

cost containment with a national health care budget and control over wasteful paperwork and procedures;

fair-share financing with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis;

public accountability with the structure being shaped by consumers' interests, not insurance companies' or pharmaceutical companies' profitability, and with consumers well-represented on all boards overseeing health care; and

consumer choice giving consumers the freedom to choose where they will go for health care and who will provide it.

The subject of today's hearing is the following five health reform bills:

- The Affordable Health Care Now Act of 1993 (H.R. 3080)
Sponsor: Representative Michel
- Health Equity and Access Reform Today (H.R. 3704)
Sponsor: Representative Thomas
- Health Plan Purchasing Cooperative Act of 1993 (H.R. 3652)
Sponsor: Representative Johnson
- The Managed Competition Act of 1993 (H.R. 3222)
Sponsors: Representatives Cooper and Grandy
- The Consumer Choice Health Security Act (H.R. 3698)
Sponsor: Representative Stearns

¹Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

To analyze these proposals, we have created a checklist of consumer concerns in health reform. The table summarizes the performance of each of the bills against the checklist. Our conclusion is unambiguous. None of these bills -- however well-intentioned they may be -- comes close to meeting the needs of consumers. While the bills offer some hope for consumers who are presently excluded from coverage due to pre-existing conditions, all five of these bills are likely to leave many people without the health care security they desire.

Two bills that are not under consideration today do much better at meeting consumers' needs. Consumers Union continues to believe that the McDermott/Conyers single payer plan is the best option. The Administration's Health Security Act would also offer consumers health care security. Consumers Union has issued an analysis of the Clinton plan. A copy of our recommendations for how to make it better serve consumers is attached.

The remainder of my testimony describes twelve "consumer checklist" issues and analyzes how the five bills address each issue.

CONSUMER CHECKLIST: ANALYSIS OF FIVE HEALTH REFORM BILLS

• DOES THE BILL PROVIDE FOR UNIVERSAL COVERAGE?

Description of the issue: No question can be more central to the success of health care reform than the issue of universality -- health care coverage for all regardless of age, income, employment status or health status. We believe that universality is so important, that it should NOT be dependent on achieving cost savings, and must not be phased-in with a vague timetable. As long as insurance coverage is voluntary, there will continue to be horror stories of the suffering of families who are left out of the system -- families will continue to face financial hardship of uncovered health bills, children will not get the health services they need, insurance companies will continue to game the system to find ways to select the best risks and leave people in need uncovered.

Americans want universal coverage -- last week's USA Today/CNN/Gallup Poll found that 79 percent of respondents favor reform that provides **guaranteed health care for everyone**.

Analysis of the bills:

• **H.R. 3080 (Michel).** H.R. 3080 does not provide universal coverage. Coverage under the bill is **voluntary**. There is neither an employer nor an individual mandate to purchase insurance, and no proven method to finance coverage for those who cannot afford it. Last year, the Congressional Budget Office estimated that a predecessor bill (H.R. 5919) would leave 39 million people without coverage in the year 2000.

Even the insurance reforms in H.R. 3080 (such as guaranteed issue or renewal) that are designed to assure universal access to coverage (though not universal coverage) do not apply to all firms, but only to firms with 2 to 50 employees. This leaves individuals and employees of large firms with the very real prospect of being excluded from coverage.

• **H.R. 3704 (Thomas).** H.R. 3704 is unlikely to result in universal coverage. While the bill includes an individual mandate to purchase insurance by the year 2005, there is a loophole -- low-income families would not be required to be insured if there are not adequate savings to fund subsidies for them. Even families that are required to buy insurance may be unable to afford it (despite the mandate), because there are no limits on premiums and no required contribution from employers.

• **H.R. 3652 (Johnson).** H.R. 3652 aims to assure access to health coverage to individuals and employees, but not universal coverage. Each state would establish one or more health plan purchasing cooperatives to enable employees of small companies and individuals to have access to insurance. H.R. 3652 contains neither an individual nor an employer mandate, and is likely to leave millions of people without insurance because they can not afford to pay the premiums.

• **H.R. 3222 (Cooper and Grandy).** H.R. 3222 creates health insurance purchasing cooperatives through which small businesses and individuals could purchase insurance, possibly increasing the affordability and availability of insurance to employees of small companies. Some low-income families who are not now eligible for Medicaid would be eligible for subsidies (for an unspecified benefit package), thereby increasing the chance that they will have some protection. Families purchasing individual policies today might receive some reduction in premiums because of the voluntary purchasing cooperatives.

However, universal coverage is not guaranteed because coverage remains **voluntary**. The Congressional Budget Office estimated that H.R. 5936, last year's predecessor bill, would leave 25 million people without insurance in the year 2000. Insurance would remain unaffordable for millions of American families.

- **H.R. 3698 (Stearns).** H.R. 3698 is unlikely to provide universal coverage. While the bill includes an individual mandate with severe financial penalties for failing to buy insurance (elimination of personal tax exemption), it does not make clear how families will be able to afford the coverage.

- **DOES THE BILL REQUIRE AN EMPLOYER CONTRIBUTION?**

Description of the issue: We believe that a required employer contribution is needed to pay for a reformed health care system. Private employers will pay premiums totalling \$185 billion in 1994, approximately 20 percent of the nation's health care spending. Without a mandatory contribution, this figure is very likely to decrease as employers continue the trend of responding to high costs by cutting health care benefits (for employees and/or dependents). Shifting the entire premium to individuals, even with subsidization of the premium for the lowest income families, will put a very steep burden on many families and is likely to result in premiums being unaffordable by many families. Not only will this leave millions of people without insurance, but it will mean that their families -- children with diabetes, fathers with high blood pressure, grandmothers with Alzheimer's disease -- will be subject to pre-existing condition exclusions (typically for a period of six months) if they are able to afford health care coverage in the future.

Analysis of the bills:

- **H.R. 3080 (Michel).** Employers are not required to make a contribution toward employees' premiums. Many (but not all)² employers are required to offer insurance coverage to their employees.

- **H.R. 3704 (Thomas).** Employers are not required to contribute toward the cost of employees' premiums; they are required only to offer coverage to employees.

- **H.R. 3652 (Johnson).** H.R. 3652 does not require an employer contribution. It requires that small employers offer employees a choice of at least three different insurance plans, "medisave" coverage, a fee-for-service plan, and a managed care plan.

- **H.R. 3222 (Cooper and Grandy).** Employers are not required to make a contribution toward employees' premiums, but are only required to offer coverage.

- **H.R. 3698 (Stearns).** Employers are not required to contribute toward the cost of employees' premiums. H.R. 3698 shifts insurance decisions from employers to individuals, by ending employer insurance expense tax exclusions and limiting deductibility of individuals' insurance premiums. If employers stop contributing to employees' health insurance premiums, they will be required to add the value of their contributions to employees' wages.

- **DOES THE BILL EXPLICITLY DEFINE A COMPREHENSIVE BENEFITS PACKAGE?**

Description of the issue: Consumers want comprehensive benefits in a guaranteed benefits package. About 90 percent of consumers polled in a Consumers Union/Gallup poll in April 1993 favored including doctor care, hospitalization, prescription drugs, well-child visits and immunizations, nursing home care, long-term care at home, mental health treatment, dental care, prenatal care, and vision care in the benefits package.

Consumers need comprehensive benefits because the private market has incentives to exclude coverage for your most likely health care needs. The cliché that you can't buy fire insurance when the barn is already burning applies to health insurance -- once a family needs long-term care, insulin for diabetes, chemotherapy to treat cancer, insurance companies prefer not to take your call. Each family has its own unique health profile and its own set of health care needs. As long as there are gaps in coverage, there will be horror stories where the lack of coverage prevented needed treatment and resulted in poor health outcomes or more expensive treatments.

Congress should not leave the design of the benefits package to a benefits commission. Passing health reform with an unspecified benefits package is like an arranged marriage -- you simply don't know what you're getting! Consumers Union would never recommend that a consumer buy any insurance policy without reading the fine print that could limit coverage. Passing the buck to a commission does not even give the American taxpayer an opportunity to read the fine print, and threatens to reduce the health benefits many people have worked hard to attain.

If Congress designs a barebones benefits package, the market response is both predictable and alarming. Insurance companies that are excluded from participating in health alliances (probably because they are less efficient and provide less value) will rush in to find their market

²For example, new businesses do not have to offer coverage for two years.

niche -- the supplemental market. All of the problems that have plagued the medigap market for 25 years before Congress enacted the successful reform plan in 1990, will be shifted to the supplemental market. There will be pre-existing conditions, denied coverage, frivolous variations in policies. The bottom line will be a multi-tiered health care system.

Analysis of the bills:

- **H.R. 3080 (Michel).** H.R. 3080 does not define the specific benefit plan. It allows the National Association of Insurance Commissioners to set actuarial guidelines for benefits; insurers would be allowed to vary the actual benefits if they stay within the actuarial guidelines. H.R. 3080 requires that in setting the actuarial target, benefits for MedAccess plans (which must be offered to small employers) should include only medical, surgical, hospital and preventive services, but it also states that "no specific procedure or treatment, or classes thereof, is required to be covered in such a plan, by this Act or through regulations." Therefore, even basic coverage is not guaranteed in the health plans offered by small employers. In addition, important benefits such as prescription drugs, mental health care, home care, durable medical equipment, hospice, and long-term care are missing from the list.

H.R. 3080 further limits coverage by setting an "essential and medically necessary" standard which is more restrictive than other alternatives which use language such as "medically necessary or appropriate." Increased insurance company restriction of benefits and intrusion into the doctor/patient relationship are likely to result.

- **H.R. 3704 (Thomas).** A Benefits Commission would develop a benefits package. It could (but would not be required to) include the following categories of benefits: medical and surgical services, medical equipment, prescription drugs, preventive services, rehabilitation and home health services related to an acute care episode, services for severe mental illness, substance abuse services, hospital services, and emergency transportation. The Commission could delete services from this list. Not included on the list are long-term care services or full mental health services.

- **H.R. 3652 (Johnson).** The Secretary of Health and Human Services would establish a standard benefit package for small employers, but the scope of benefits is not clear.

- **H.R. 3222 (Cooper and Grandy).** A Health Care Standards Commission would establish a uniform benefit package that must be offered by accountable health plans. The Commission's recommended benefit package would be considered for approval by the Congress. H.R. 3222 requires that the benefits package include "the full range of effective clinical preventive services." There is no guarantee that the benefits package would be comprehensive, including coverage for prescription drugs, mental health care, long-term care, or other needed health care.

- **H.R. 3698 (Stearns).** Qualified plans must include physician and hospital services and prescription drugs, but are not required to include prenatal care, well-child care, mental health care, or long-term care. The Department of Health and Human Services and state insurance commissions would develop and enforce coverage standards.

- **DOES THE BILL ALLOW FOR A "CATASTROPHIC ONLY" OPTION, WITH DEDUCTIBLES OF \$2000 OR \$3000 PER FAMILY?**

Description of the issue: The promise of comprehensive benefits will be hollow if families can buy a catastrophic insurance policy with a \$2000 or \$3000 deductible, and be considered "insured." A \$3000 deductible does not deliver preventive care to children, \$2500 worth of insulin to a diabetic, or many other pressing health care needs.

Many low- and middle-income families will not get access to comprehensive care. Instead, they will end up with an unfunded Medical Savings Account and a catastrophic policy with a \$2000 or \$3000 deductible. Financial barriers to health care will continue for these families.

Analysis of the bills:

- **H.R. 3080 (Michel).** The bill encourages catastrophic health insurance policies with individual deductibles of \$1800 and family deductibles of \$3600.

- **H.R. 3704 (Thomas).** H.R. 3704 encourages the purchase of a catastrophic insurance policy with high deductibles.

- **H.R. 3652 (Johnson).** H.R. 3652 would allow for a "qualified catastrophic health plan" to be considered insurance coverage. The individual deductible would be \$2000, and the family deductible would be \$4000.

- **H.R. 3222 (Cooper and Grandy).** The bill does not allow for a catastrophic only coverage to qualify as insurance coverage.

- **H.R. 3698 (Stearns).** H.R. 3698 encourages the purchase of catastrophic health insurance with a \$1000 deductible for single individuals and \$2000 deductible for families.

• **DOES THE BILL REIGN IN HEALTH CARE COSTS THROUGH CONTROLS ON BOTH THE PUBLIC AND PRIVATE SECTOR?**

Description of the issue: Global budgets and premium caps to curb cost growth in both the public and private sector health spending are essential. This protection should not be sacrificed to give the failed "free market" cost containment efforts yet another chance to drive up health care costs. Two other essential ingredients to help curb growing health care costs are banning balance billing and prohibiting physician self-referral. These are two culprits that have contributed to today's high costs. In addition, we urge you to oppose granting antitrust exemptions for doctors, hospitals, and pharmaceutical companies. Legislation should not create new antitrust exemptions that would allow doctors to collude in negotiating any reimbursement schedules.

Analysis of the bills:

• **H.R. 3080 (Michel).** H.R. 3080 does not control either public or private health spending. The Congressional Budget Office estimated that H.R. 5919 (a predecessor bill) would have virtually no effect either on near-term or far-term health care savings.

• **H.R. 3704 (Thomas).** H.R. 3704 constrains public spending (for Medicare and Medicaid) but relies on price competition and market forces to constrain private spending. H.R. 3704 encourages the purchase of low cost insurance by setting a cap (equal to lowest half of certified plans in an area) on deductibility of individuals' insurance premiums from income (for income tax purposes). There are no provisions that guarantee cost savings in the private sector.

• **H.R. 3652 (Johnson).** H.R. 3652 contains no guarantees of health care cost control in either the private or the public sector. Instead, it relies on increased price competition that will result from a standardized benefit package, and catastrophic policies that would discourage utilization of health care services.

• **H.R. 3222 (Cooper and Grandy).** H.R. 3222 creates tax incentives for employers to offer low-cost health insurance plans only, and relies on the free market forces to control health care costs. It restricts future Medicare spending by reducing payments for providers (and reduces Medicare savings by increasing Part B premiums for high income individuals). H.R. 3222 would not expand Medicare benefits to include prescription drugs or community based care (though it includes a "sense of Congress" that these benefits should be expanded in the future if savings allow). It repeals the Medicaid program, covering people with income below 100 percent of poverty through purchasing cooperatives (with subsidies for others up to 200 percent of poverty), and turns the long-term care portion of Medicaid over to the states. Cost savings from the public sector (Medicare and Medicaid) are likely to be substantial; cost savings from the private sector are less certain and are by no means guaranteed.

• **H.R. 3698 (Stearns).** H.R. 3698 does not have global budgets or premium limits, relying instead on price competition to limit private sector costs. At the same time, it imposes limits on Medicare and Medicaid spending.

• **DOES THE BILL REIGN IN PRESCRIPTION DRUG COSTS?**

Description of the issue: Two recently released reports demonstrate the failure of the free market to lead to consumer-friendly prices for prescription drugs. A report³ by the Senate Special Committee on Aging staff found that during 1993, prescription drug prices increased 15.5 times greater than the overall rate of inflation. A new General Accounting Office report estimated that on average U.S. consumers pay 60 percent higher prices for identical prescription medications than do their counterparts in England.

The United States is the only industrialized country that makes no effort to regulate drug prices, forcing U.S. consumers to pay higher prices and to help pay for research that benefits citizens of other countries, who pay much lower prices. The Office of Technology Assessment reported that during the 1980's, pharmaceutical companies on average earned about 15 to 30 percent more profit than was needed to attract adequate investment capital. If drug prices were a river, they would already be well over flood stage. A critical ingredient of a reformed health care system is prescription drug pricing that is accountable to consumers, not the bottom line profitability of the pharmaceutical industry.

Analysis of the bills:

• **H.R. 3080 (Michel); H.R. 3704 (Thomas); H.R. 3652 (Johnson); H.R. 3222 (Cooper and Grandy); and H.R. 3698 (Stearns).** None of these bills regulates prescription drug

³"A Report on 1993 Pharmaceutical Price Inflation: Drug Prices for Older Americans Still Increasing Much Faster than Inflation," January 1994.

prices.

• **DOES THE BILL ALLOW FOR FREEDOM OF CHOICE OF DOCTORS?**

Description of the issue: Freedom to choose their health care provider is one of the most highly valued features that consumers seek in the health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Often, one family will have an array of doctors, making it impossible to follow them all to one HMO. Consumers want to be assured that if serious illness strikes, they will have access to the highest quality specialist and specialized treatment centers.

But freedom of choice of provider is a meaningless freedom if the high cost of insurance premiums render it unaffordable, leaving many families with not coverage at all. In addition, to the extent that proposals provide strong financial inducements (that may even make traditional fee-for-service out of the question) for families to enroll in managed care networks, these families will have restricted freedom of choice of provider, especially if the bill does not build in (as does the Health Security Act) a point-of-service requirement that would allow you to go outside of your network.

Analysis of the bills:

• **H.R. 3080 (Michel).** Freedom of choice of provider is limited for many reasons: millions of uninsured consumers will continue to have extremely limited options because of the lack of insurance; consumers who are offered (by their employer) one plan such as an HMO will be constrained to the providers offered by that HMO; consumers who are offered a catastrophic plan and are unable to afford to contribute to a Medical Savings Account will have limited choice of provider.

• **H.R. 3704 (Thomas).** Many families will face reduced freedom of choice of doctor under H.R. 3704. This results from the cap on deductibility of health insurance premiums. Limited funds will force many families to enroll in managed care plans, and will force many other families to buy catastrophic only policies. These families -- as well as those that can't afford insurance at all (despite the individual mandate) will face restricted choice of providers. There is no provision to allow enrollees in HMO's to have the opportunity to go outside of the network for care. H.R. 3704 encourages expansion of managed care contracts for Medicaid, possibly further restricting the Medicaid population's choice of provider.

• **H.R. 3652 (Johnson).** H.R. 3652 does not include any provisions (e.g., such as limitations on tax deductibility) that would provide strong financial incentives for employers to offer or individuals to purchase a managed care health plan. It is unlikely, therefore, to have a major impact on consumers' freedom to choose a physician. The bill does not require HMO's to offer a point-of-service option to consumers.

• **H.R. 3222 (Cooper and Grandy).** Many families would find their freedom to choose a health care provider would be reduced if H.R. 3222 were enacted. Employers will face a stiff tax to the extent that they provide coverage for their employees that exceeds the lowest cost plan offered in a purchasing cooperative. Self-employed individuals would be able to deduct premium costs from their income taxes only up to the level of the low-cost health plan. Subsidies for low-income consumers are based on the least-cost plan in the region. The effect of these provisions is to provide a very strong incentive (and in the case of employer provided coverage a necessity) for people to enroll in the lowest cost health plan available. In many cases, the lowest cost plan will be a Health Maintenance Organization. There is no provision in H.R. 3222 to build in protections to assure that consumers enrolled in an HMO will have the ability to go outside of the HMO for care if they need (or choose) to do so.

• **H.R. 3698 (Stearns).** Changes in tax treatment of premiums are likely to result in more people being enrolled in managed care, with restricted provider choice. The bill does not build in a point-of-service requirement that would allow HMO enrollees to go outside their HMO for care.

• **DOES THE BILL EXPAND ACCOUNTABILITY TO CONSUMERS OR IS THE SYSTEM ACCOUNTABLE TO INSURANCE OR PHARMACEUTICAL COMPANIES' BOTTOM LINE?**

Description of the issue: The recent health care crisis has resulted, at least in part, from the profit-maximizing strategies of insurance companies to cherry pick the best health care risks and deny coverage (or impose pre-existing condition restrictions) to people who are higher risks. If a reform proposal allows for a major role for insurance companies, then there are several critical ingredients needed to provide for accountability to the public. For example, is the

insurance company (or health plan) allowed to undercut standardization by deciding which experimental treatment to cover, or by using its own utilization review company or treatment protocols? Are insurance policyholders able to appeal treatment denials and other complaints in a timely matter through an appeals process located OUTSIDE of the insurance company to assure objectivity? Are any medical malpractice "reforms" designed with the objective of decreasing the incidence of medical malpractice and fairly compensating injured consumers, or are they unfairly limiting compensation to the most seriously injured victims of physician negligence?⁴

Analysis of the bills:

- **H.R. 3080 (Michel).** The health care system remains accountable in large part to the profitability of insurance and pharmaceutical companies, not consumers. The bill includes anti-consumer medical malpractice reforms such as capping noneconomic damages that can be awarded to an injured patient at \$250,000. The bill does not provide for expanded consumer representation in the health care system.

- **H.R. 3704 (Thomas).** The bill includes several elements that expand accountability to the public: the Secretary of the Department of Health and Human Services must develop and publish standards that quality assurance programs must comply with. The federal government would also develop a national health data system that would provide information about health plans. States would be responsible for implementing insurance market reforms. The 5 member Benefits Commission (appointed by the President in consultation with various Leaders of Congress) would be composed of people from a mix of professions (with geographic balance and urban/rural balance), but could include physicians and other providers of health care services. While employer representatives could be included, there is no provision for representation of consumers on the commission. H.R. 3794 restricts noneconomic damages for victims of medical malpractice to \$250,000.

Overall, H.R. 3704 allows insurance and pharmaceutical company profitability to drive many of the decisions in the health care marketplace.

- **H.R. 3652 (Johnson).** The Secretary of Health and Human Services would have increased regulatory responsibilities, possibly expanding accountability of the health insurance system to the public. The Boards of Directors of purchasing cooperatives would include a majority of members that are either small employers or "eligible individuals that participate in the Cooperative." While there is no requirement that the board include consumer representatives, the requirement that future board members be elected by small employer members and individual members could help increase accountability of cooperatives to the public. Unfortunately, the language regarding advisory committees suggests that these committees should consist of representatives from health plans, agents, and health care providers, but not consumers. Overall, this legislation preserves too much control of the health care system in the hands of insurance and pharmaceutical companies.

H.R. 3542 does not include any provisions that would limit consumers' access to fair treatment in the medical malpractice system.

- **H.R. 3222 (Cooper and Grandy).** To the extent that individuals and small employers are pooled in purchasing alliances, they will have increased bargaining power under H.R. 3222. Beyond this, however, H.R. 3222 does little to increase accountability of the health care system to consumers, and includes some provisions that reduce accountability to consumers. While there is a provision prohibiting members of each health plan purchasing cooperative (HPPC) from receiving remuneration for services from any accountable health plan, there is no assurance that the members will be selected based on their ability to represent the public (or employers') interests. The cooperative is not required to have any consumer members. Bottom-line profitability of insurance companies and pharmaceutical companies will continue to be a major driving force of the health care system. In addition, the bill limits medical malpractice awards on noneconomic damages to \$250,000.

- **H.R. 3698 (Stearns).** Profitability of insurance and pharmaceutical companies will continue to be a driving force of the nation's health care system. Expanded regulatory roles by the Secretary of the Department of Health and Human Services and the National Association of Insurance Commissioners could help somewhat, but offer little assurance of increased consumer participation. The bill limits medical malpractice awards on noneconomic damages to \$250,000, contrary to consumers' interests.

⁴The Congressional Budget Office has concluded that so-called medical malpractice reforms such as capping damages for pain and suffering do not produce measurable health care savings.

● **WILL PREMIUMS BE A FINANCIAL BARRIER TO HEALTH CARE COVERAGE FOR SOME FAMILIES?**

Description of the issue: Our current health care system is financed in the most regressive way possible -- through unreimbursed out-of-pocket health expenses and flat premiums that are most burdensome to low-income families. Because of uncovered expenses and the experience-rated premium structure, the sicker you are, the more you pay. Consumers Union favors overhauling the financing of health care, by financing reform based on ability to pay. We prefer increased payroll taxes and income taxes to premiums. If premiums are to be used, then we favor subsidies for low-income consumers. We support discounts geared to income that will assure that all families will have protection without facing burdensome premiums.

Analysis of the bills:

● **H.R. 3080 (Michel).** Under H.R. 3080, premiums will continue to present financial barriers to coverage for many families. Many families would be required to pay 100 percent of the cost of an unlimited premium, with no limit on the percentage of family income paid for premiums. The bill provides very limited protections to small firms (with less than 51 employees): insurers could vary premiums among classes of small businesses by 20 percent, and could charge small businesses within the same class 150 percent of the base premium for that class (falling to 135 percent eventually). Small employers would have premium increases limited to 15 percent plus the premium rate increase for a newly-covered small employer within the same class of business rate.

● **H.R. 3704 (Thomas).** Premiums could present a financial barrier for many families. While there are vouchers for low-income families, the availability and amount of those vouchers are uncertain. Many families would be required to pay 100 percent of the cost of an unlimited premium, with no limit on the percentage of family income paid for premiums.

● **H.R. 3652 (Johnson).** Within purchasing cooperatives, premiums would not be allowed to vary based on health risks, and a risk adjustment mechanism in the bill provides for adjustments in payments to health plans to assure that people with existing conditions should not be discriminated against. Premiums could vary by age, gender, and number of family members, lessening this bill's "community rating." There are no controls on premium increases, no limit of percent of income that must be spent on premiums, no required employer contribution and no spelled-out subsidies to help low-income families pay for premiums. As a result, high premiums are likely to keep many families from being able to purchase health insurance.

● **H.R. 3222 (Cooper and Grandy).** Premiums will continue to be unaffordable for many families. Premium subsidies for low-income families will help these families purchase the least-cost plan (but they are unlikely to be able to afford a policy that costs more than the least-cost policy). The bill does not impose limits on health insurance premiums, even as a backstop in the event that market forces are unsuccessful in controlling premiums. H.R. 3222 includes no limit on percentage of income that must be spent on premiums. A couple (without children) earning \$20,000 would be ineligible for any subsidy and is unlikely to be able to afford health insurance premiums. A family of four earning \$22,000 would be eligible for a partial subsidy, but (without a required employer contribution) would be unlikely to afford to buy health insurance.

● **H.R. 3698 (Stearns).** Tax credits will help ease the burden of premiums, but many families will face hardship from paying premiums, especially since employers are not required to contribute toward premiums. There is no percent of income limit on premiums. Premiums can continue to increase, free from any government controls.

● **WILL OUT-OF-POCKET COSTS SUCH AS DEDUCTIBLES AND COINSURANCE PRESENT FINANCIAL BARRIERS TO HEALTH CARE?**

Description of the issue: It is critical that deductibles and coinsurance not present financial barriers to care, and that health reform include subsidies for cost-sharing for low-income consumers and special protections (e.g., waivers of cost-sharing) to provide flexibility to assure that the inability to come up with a few dollars for a prescription or \$10 for a doctor's visit never be the cause of denied care.

Analysis of the bills:

● **H.R. 3080 (Michel).** Apart from the possibility of "catastrophic only" coverage, families would be required to pay "substantial" but unspecified, cost-sharing under the standard plan. This required cost-sharing could create a financial barrier to care.

● **H.R. 3704 (Thomas).** Apart from "catastrophic only coverage, families will face cost-sharing that could present a barrier to care. The Commission will determine the cost-sharing limits.

- **H.R. 3652 (Johnson).** Under H.R. 3652, deductibles and cost-sharing (without any subsidies for low-income families) could present a barrier to care.

- **H.R. 3222 (Cooper and Grandy).** With the exception of preventive care, there are no limits on deductibles and copayments for covered services. Low-income families would have some protection because cost-sharing must be "nominal" for low-income families. (The Commission would determine what cost-sharing would be considered to be "nominal.") Cost-sharing could, therefore, continue to present financial barriers to health care. The Commission would set an out-of-pocket limit on expenses, so families with insurance coverage would have some protection (but families without insurance would have none).

- **H.R. 3698 (Stearns).** A \$5000 limit on annual family out-of-pocket expenses limits each family's total liability. However, cost-sharing limits are unspecified and could prove burdensome.

- **WILL THE BILL CREATE A MULTI-TIER SYSTEM WITH DIFFERENT LEVELS OF QUALITY AND DIFFERENT LEVELS OF COVERAGE THAT DEPEND ON INCOME, AGE, EMPLOYMENT, OR HEALTH STATUS?**

Description of the issue: The Consumers Union/Gallup poll (April 1993) showed clearly that Americans want a single, comprehensive health care plan that covers everyone, regardless of income, age, employment or health status. Will legislation result in the continuation of a separate program for low-income families, with different provider reimbursement levels and inferior care? Will benefits be the same regardless of age? Will employed individuals have Cadillac coverage, while unemployed are stuck with barebones coverage (or even no coverage)? Will insurers continue to charge higher premiums based on pre-existing conditions, pushing the less healthy into less comprehensive coverage plans?

Analysis of the bills:

- **H.R. 3080 (Michel).** H.R. 3080 gives states the option of expanding Medicaid by allowing a buy-in option for persons up to 200 percent of poverty. But this option would be funded by using existing Medicaid funds (including funds for disproportionate share hospitals, meaning that there would be a reduction in the quality and level of benefits available to existing beneficiaries).

- **H.R. 3704 (Thomas).** H.R. 3704 imposes a cap on Medicaid spending that could further erode the quality of care (and access to providers) to Medicaid enrollees. Medicare and Medicaid enrollees might find it difficult to find a doctor to treat them in light of the lack of uniform payments for providers. Low-income families could find themselves in low cost health plans with low quality, with insurance premium and health plan quality increasing with income.

- **H.R. 3652 (Johnson).** A multi-tiered health care system would continue to exist under H.R. 3652. Large employers would not be part of the purchasing cooperatives. Separate Medicare and Medicaid programs would continue, with differential provider payments (and restricted access to care). Low-income families would have limited options when it comes to their health insurance, and many would find themselves without any coverage at all.

- **H.R. 3222 (Cooper and Grandy).** The incentives (on employers, the self-employed, and subsidized families) to enroll in the least cost plan are very strong and could result in a continued multi-tiered health care system. People with low incomes and with employers who want to avoid higher taxes will end up with the lowest cost health plan in their region; this is likely to be the lowest quality health plan, and these families will not have the ability to buy a higher priced plan. Higher income self-employed individuals, and employees with more generous employers (or employers who will adjust wages to reflect changes in their health costs) can afford to pay the full cost (without tax benefits) of higher quality plans. Medicare providers could be reimbursed at rates below those of non-Medicare providers, resulting in different levels of care and accessibility for the Medicare population.

- **H.R. 3698 (Stearns).** The lack of uniform payments (e.g., for Medicaid) and the financial incentives to buy low-cost (and catastrophic) insurance will perpetuate, and possibly aggravate, a multi-tiered health care system.

- **WILL PRE-EXISTING CONDITION RESTRICTIONS CONTINUE TO LEAVE SOME PEOPLE UNCOVERED?**

Description of the issue: Pre-existing conditions limit the health insurance options for 81 million Americans. Many supporters of a voluntary approach proclaim the fact that problems of "pre-existing condition" restrictions will be solved by this type of bill. But in fact, pre-existing

condition restrictions will continue to exist under reform that is voluntary, and even under bills with an individual mandate. Without a six-month pre-existing condition restriction, consumers would be rewarded for avoiding premiums and being uninsured while they are healthy, and then buying health insurance when they are sick. Yet as long as there are "pre-existing condition" periods of six months in a bill, children with diabetes, children in need of therapy, pregnant women, and millions of others who get sick, will have their own horror story to tell about the gaps in the system.

Analysis of the bills:

- **H.R. 3080 (Michel).** H.R. 3080 does not eliminate the use of pre-existing condition clauses. The limits in on pre-existing condition clauses in H.R. 3080 apply only to group health plans. Individuals with pre-existing health conditions are not protected, and may be charged significantly higher premiums or denied coverage altogether. Even in group health plans, a six-month limitation or exclusion is allowed except for newborns covered under the plan and pregnancy. Anyone (including children) who is not continually insured (and many will fall in and out of the insurance system, since premiums may be unaffordable) could face six month gaps in coverage for pre-existing conditions.

- **H.R. 3704 (Thomas).** H.R. 3704 limits pre-existing condition restrictions to a period of 6 months, excluding pregnancy from these restrictions. An individual or family that goes for a period of time without health insurance could face a six-month period with limited coverage.

- **H.R. 3652 (Johnson).** While H.R. 3652 includes provisions for modified community rating, assured renewal (with a few exceptions), and open enrollment, it defers to state law on matters relating to rating, underwriting, claims handling, sales solicitation, licensing, and unfair trade practices. It is not clear what the limitations on pre-existing condition restrictions would be.

- **H.R. 3222 (Cooper and Grandy).** Consumers will be able to avoid preexisting condition restrictions under H.R. 3222 only if they have continuous insurance protection — something that is unlikely to be the case for millions of American families who are unable to afford to pay premiums continuously. Accountable health plans are allowed to limit coverage for preexisting conditions for a period of 6 months for conditions that were diagnosed or treated within 3 months of the beginning of coverage. The only exceptions are for newborns and pregnant women.

- **H.R. 3698 (Stearns).** Consumers (and their families) who have had a break in their insurance coverage can be subject to pre-existing condition restrictions for as long as one year.

In sum, the popular slogan of the week regarding crime control "3 strikes and you're out" can be applied to health care reform:

- Strike one: make participation (and employer contribution) voluntary;
- Strike two: pass the buck on defining benefits to an outside commission;
- Strike three: encourage catastrophic policies with a \$3000 deductible.

Any of these crucial mistakes will totally undermine health care reform, and result in gaps in coverage and continuing suffering, lack of needed health care, and financial barriers to care. We urge you to avoid these mistakes, and assure that consumers' dream for universal, comprehensive health care benefits becomes a reality. The five bills under consideration by this Subcommittee, regrettably, strike out when it comes to meeting the needs of consumers.

**25 Ways to Make A Good Plan Even Better
Recommended Changes to the Health Security Act
Consumers Union**

1. Make the benefits provided by health plans truly standard. Require all health plans in any regional alliance to have the same treatment protocols, including policies toward experimental treatments.
2. Require the alliances to handle disputes and appeals for denied treatment.
3. Integrate all segments of the population into a single system with a global budget within five years.
4. If market conditions warrant (an area has too few high-quality, low-cost health plans available), require alliances to create a Medicare-buy-in type of option that allows consumers to get coverage outside of the insurance industry.
5. Expand benefits to include nursing home care, expanded home care, more extensive mental health care, and care for children with congenital problems.
6. Require that alliances limit fee-for-service plans to one in order to achieve administrative cost savings and avoid risk selection problems.
7. Limit the difference in cost between fee-for-service plans and the average premium plan so that low- and middle-income consumers can enjoy freedom-of-choice of health care providers. (This is especially important for migrant workers.)
8. Protect low-income consumers by reducing the portion of income that must be spent on premiums to 2 percent, by expanding the premium discount for low-income consumers, and by reducing or eliminating the cost-sharing required of low-income persons.
9. Standardize the supplemental benefits market.
10. Provide the National Health Board with authority to regulate -- and roll back -- prescription drug prices.
11. Give the National Health Board the authority to set minimum quality and access requirements for health plans.
12. Eliminate the antitrust exemption that allows doctors to rig bids.
13. Modify the medical malpractice reforms so that they serve consumers' interests.
14. Establish a national guaranty fund for health plans. This fund would pay outstanding policyholder claims in the event of company insolvency.
15. Regulate health plan finances to protect consumers. Specifically, expand federal capital and surplus standards to cover all health plans and health alliances; health plan assets should be separate from the rest of a company's assets. Antitrust laws should be extended and exemptions should be limited to prevent companies from using predatory pricing practices in non-health portion of business to bolster health plan business.
16. Expand counseling programs (that now serve senior citizens) so that all consumers have access to an objective source of advice about selection of health plans.
17. Improve the regulation of the private long-term care insurance market.
18. Exempt low-income senior citizens (those earning up to about 150 percent of the poverty line) from the increase in the Medicare Part B premium.
19. Provide for nationwide risk adjustment, so that the costs associated with high-risk

populations are spread fairly. This is the only way that small groups of high-risk populations (who may be grouped within one regional alliance) will not pay disproportionately higher premiums. In addition to health problems, risk adjustment should include non-health related factors that can restrict access to health care, such as transportation, translation, and other related services.

20. Adjust the subsidy for early retirees so that those with incomes substantially above the poverty level pay their fair share of health care costs.
21. Ban hospital indemnity and dread disease policies.
22. Ban variations on the standard benefit package.
23. Require insurance companies to have legitimate consumer representation on boards; expose insurance company executives' salaries to public scrutiny.
24. The plan should be consistent in how it deals with supplemental insurance policies designed to cover cost-sharing, or the out-of-pocket expenses a consumer would face. Either this coverage should be banned across the board, or it should be allowed under both low cost-sharing plans and high cost-sharing plans.
25. Impose an income tax surtax, a tax on new hospital revenues that are created by reduced spending for uncompensated care, and increase the tax on corporate alliances to pay for additional benefits and subsidies.

FIVE/FIVE PLAN FOR HEALTH CARE REFORM
CONSUMERS UNION
FEBRUARY 4, 1994

Congress should fight hard against special interests to preserve these important provisions of the Health Security Act:

1. Universal health care must be a reality within three or four years.
2. Cost containment through limits on public and private spending must be kept.
3. Employers must be required to contribute to the cost of their employees' health care.
4. Keep the benefits package comprehensive.
5. Maintain the state single payer option.

Congress should improve the Health Security Act to make it better serve the needs of consumers:

1. Protect low- and middle- income consumers from facing financial barriers to care or burdensome premiums.
2. Increase accountability to consumers by prohibiting insurance companies from varying the benefits offered within each alliance, by shifting the appeals process outside the insurance company, and by reducing the ability of insurance companies to deny coverage.
3. Make freedom-of-choice of provider a real option for people of all income levels by requiring all health alliances to offer a fee-for-service plan that costs little more than the average cost plan.
4. Include the blueprint for phasing-in nursing home benefits and expanded community care benefits.
5. Give the National Health Board the authority to regulate prescription drug prices that apply to all Americans.

**SUMMARY: FIVE HEALTH REFORM BILLS:
DO THEY MEET CONSUMERS' NEEDS?**

CONSUMERS' NEED:	BILL:	H.R. 3080 MICHEL	H.R. 3704 THOMAS	H.R. 3652 JOHNSON	H.R. 3222 COOPER/GRANDY	H.R. 3698 STEARNS
Universal Coverage		X	?	X	X	?
Employer Contribution		X	X	X	X	X
Comprehensive Defined Benefits		X	X	X	X	X
No "Catastrophic Only" Option		X	X	X	✓	X
Costs Controls: Public & Private		X	X	X	X	X
Prescription Drug Costs		X	X	X	X	X
Freedom of Choice of Provider		X	X	N	X	X
Accountability to Consumers		X	X	X	X	X
Premiums: Not a Financial Barrier		X	X	X	X	X
Deductibles/Coinsurance: Not a Financial Barrier		X	X	X	X	X
No Multi-tier System		X	X	X	X	X
No Pre-existing Condition Restrictions		X	X	?	X	X

Key: X = does not meet consumers' needs
 ? = unclear whether meets consumers' needs
 ✓ = meets consumers' needs
 N = no major impact

Chairman STARK. Thank you.
Ms. Bailey.

**STATEMENT OF PAMELA G. BAILEY, PRESIDENT,
HEALTHCARE LEADERSHIP COUNCIL**

Ms. BAILEY. Thank you, Mr. Chairman. It is a pleasure to be here at this concluding hearing today.

I am here as a representative of the Healthcare Leadership Council, an organization of some 50 chief executives representing the 5 sectors of the health care system.

The HLC was created over 5 years ago for the sole purpose of developing and advocating solutions to our health care crisis, but our members do more than talk about reform. They have been in the forefront of the marketplace revolution that is now the hallmark of the American health care system.

What we have seen quite dramatically over these past 5 years is that the delivery system is constantly renewing itself in response to market forces, consumer demand, and innovation. Examples include the development of managed care, a focus among our manufacturing members on developing only cost-effective technologies, a recognition by our insurance members that their future is not in just processing claims and managing risk but in helping to manage health care, and a substantial deceleration in health care costs in response to probably the most important force over this past decade, the demand by employers for value in the health care provided to their employees.

We urge that legislative reform build on these market forces, not replace them with government mandates, price controls and regulations. The challenge, then, is how to design reforms that can contain costs, can lead us to universal coverage without jeopardizing the high quality, cost consciousness, and innovation that characterizes our system at its best.

The principles and key elements of the bills before this committee today are all consistent with HLC principles for health care reform. Specifically, I would like to note the provisions that we support that can enable us to work toward universal coverage without employer mandates.

By eliminating the barriers based on employment, on income, and on health status that currently keep 38 million Americans from having coverage, we see that we can move toward eliminating a significant majority of the uninsured Americans. It is our recommendation that we take a look at that point at what is left and target solutions specifically to that population, so that we can have universal coverage.

The goal of cost containment should be to get the most value out of every health care dollar spent. This means increasing efficiency by reducing administrative costs, eliminating unnecessary procedures, reforming the malpractice system, and revising antitrust regulations. In short, we advocate using market competition, not price controls, to contain costs.

Proposals to cap tax deductions would give consumers incentives to choose the highest quality, lowest-cost health plans, and we recommend that they be part of any market reform plan.

Finally, as we debate approaches to reform, it is important that we keep in mind the many areas of agreement. Unlike when we in our organization first started talking about health care reform 5 years ago, the debate is no longer over whether we need reform, nor is it even over the goals of reform. In fact, we note a significant body of agreement on measures that can get all Americans covered, can keep them covered, and can contain costs.

These areas of agreement include insurance reforms, definition of a basic benefit package, government subsidies, administrative reform, consumer information, malpractice reform, tax equity reforms, and some sort of small business purchasing pools.

It is our hope that as the committee moves forward and we participate in this process that we not lose sight of where we have made significant progress and agreement and that we can move forward to complete this process before the end of this year.

Thank you.

[The prepared statement follows:]

TESTIMONY OF PAMELA G. BAILEY HEALTHCARE LEADERSHIP COUNCIL

Good morning. My name is Pamela Bailey. I am the president of the Healthcare Leadership Council. The HLC is a group of nearly 50 CEOs from the health care industry. It originated almost five years ago from discussions among its founding members after the 1988 Presidential election. They realized then a crisis was facing our health care system, that as a nation we weren't prepared to face up to that crisis and that as leaders in the industry they had a responsibility to provide leadership toward reform. And so, the HLC was created with the sole purpose of developing and advocating action on consensus solutions to health care.

Our members are not protectors of the status quo. Quite the opposite. They are the risk takers, the entrepreneurs, the ones who seek change, who shake up the status quo. Whether it's consolidation of hospitals and the creation of doctor and hospital networks, the targeting of R&D and manufacturing on new cost-effective technology, or the recognition by our insurance members that the future for them was not to merely process claims or manage risk, but to manage health care -- our members have been in the forefront of the market place revolution that is now the hallmark of the best of American health care. Just as importantly, our members are committed to working for legislative reforms.

We applaud President Clinton's commitment to health care reform and his efforts to initiate a national discussion. Unlike five years ago, the debate this year is no longer over the need for reform, or even the goals. On both these points all Americans agree. Rather, the debate will now focus on how to achieve our shared vision without compromising the quality, choice and innovation that characterizes our nation's health care system at its best.

A REVOLUTION IN PROGRESS

Reform of the health care system is already in progress. In recent decades, there has been a revolution in the health care system. Treatments that once were cutting edge, like coronary bypass surgery, have become commonplace. High tech medical devices like diagnostic imaging and cardiac pacemakers are now widely available. And more investment in research and development has produced a wealth of new life-saving drugs. These advances have made our population healthier. Infant mortality is down and life-expectancy is up. While many U.S. industries have been hurt by world-wide competition, our health care industry has thrived. Our investment in new technologies and drugs leads the world. People from across the globe come to the United States to receive the highest quality care. In this respect, our health care system is the envy of the world. It is proof that our system does more for its patients.

There has also been a radical change in the way we buy health care coverage. Responding to market place signals, more and more of us are covered through managed care. A soon-to-be-released report by the National Committee for Quality Health Care finds that 95 percent of employed workers were participating in some kind of managed care plan by 1990.

This move toward managed care has helped to contain costs. For example, average premium increases from HMOs declined from 10.6 percent in 1992 to 8.1 percent in 1993 and are expected to drop to 5.6 percent this year. Some HLC members even report negative premium increases in the past year. Consistent with these reports, a U.S. Chamber of Commerce survey of 1,100 corporations found that the average employer's costs for medical and dental coverage decreased between 1991 and 1992 -- from \$2,811 to \$2,754 a worker. Illustrating managed care's ability to minimize unnecessary care, HMOs alone have reduced hospital admissions and total hospital days anywhere from 20 percent to 30 percent. Yet savings from these reductions outweigh the costs of increased outpatient visits.

Recent studies demonstrate the market is responding in other ways to demands for lower costs. Demands by employers and other payers for lower prices have caused increases in health care prices to drop from 9.6 percent in 1990 to 7.9 percent in 1991 to 6.6 percent in 1992. According to the Labor Department, health care prices increased only 5.5 percent between November 1992 and November 1993. This is the smallest increase since 1973 -- when health care

was subject to wage and price controls. This cost containment is not due to the fear of reform. It is part of a steady and on-going trend toward using and providing care more efficiently.

These reforms were initiated even before the impetus of health care reform legislation. They have been driven by employers, who pay most of the nation's private health care bill. Employers are turning to providers who offer low-cost, high-quality care to their employees. And providers are responding by becoming more efficient and innovative. The market is proving it can reform itself. National reform should build on this success, not short circuit it.

THE DELIVERY SYSTEM

It's important to remember there are two aspects to the health care system: the delivery system and the financing system. The issues that need to be addressed in the delivery system are access and quality of care. The issues driving the financing crisis are ones of coverage and cost; we must make sure everybody can get the quality care they need at a reasonable price.

Our delivery system is undoubtedly the best in the world. It is constantly renewing itself in response to market forces, consumer demand and innovation. Policy makers may find that the delivery of health care is changing so fast that they will soon be trying to reform a system that no longer exists in many parts of the United States.

A new National Committee for Quality Health Care report by Lewin-VHI points out that both technological advances and changes in reimbursement have lead to an increase in more cost-effective outpatient services. Investment in R&D, for example, has produced cost-saving therapies like laser surgery for cataract removal. This technological advance has saved money by shifting the procedure from an inpatient to an outpatient setting. The report also shows how hospitals were able to respond to a shortage of registered nurses that began in the late 1970s. They increased the supply and lowered the demand for registered nurses by raising the salaries of RNs and relieving them of certain tasks like making beds and delivering meals. These are just two examples of how the delivery system is effectively responding to market demand. The National Committee will release its annual index on health care trends tomorrow.

Reform legislation must not interfere with these market mechanisms. We fear that premium caps and government regulations may have the unintended consequence of lower investment in R&D. As a result, innovative new procedures like cataract laser surgery may not be developed. We are also concerned that premium caps would prevent hospitals from responding appropriately to future nursing shortages. Imposing price controls on the health care industry could force hospitals and other health care employers to freeze wages. But by imposing price controls exclusively on the health care industry, skilled health care workers would be given an incentive to leave for better-paying jobs in other industries. Even more important, price controls would freeze in place the status quo.

Instead, reform should build on what is working by providing incentives for higher quality and greater choice and innovation. By arming consumers with needed information, providers would have to compete on objective standards of quality.

THE FINANCING SYSTEM

Yet the financing system does require swift legislative reform. The incentives in the current system need to be reversed. Today, insurers too often seek to minimize risk by excluding high-risk populations. Patients and providers have little incentive to be cost conscious because the insurance company will pick up the tab. And often they don't know the true cost of their health care choices. This system results in the exclusion of many from health coverage and an inflation in health care costs. This must be changed now.

Insurers must be prohibited from excluding people with pre-existing conditions and dropping people when they become sick or change jobs. Providers and consumers must become aware of the true cost of the health care services they dispense and receive. The only way to contain costs without risking quality is to give consumers an incentive to choose the lowest-cost, highest-quality health plan and to force providers to compete on the basis of price and quality.

Congress must pass and the President must sign a bill that contains health care costs and makes coverage affordable and accessible to all -- but without jeopardizing the high-quality, choice and innovation that Americans have come to expect from their health care system. Reform should build on the positive market reforms we are now witnessing -- not replace them with government regulations and price controls.

PRINCIPLES OF REFORM

The Healthcare Leadership Council believes there are five fundamental principles of reform. They are:

- o Access: Everyone must have available to them the right treatments and facilities -- where and when they need them.
- o Coverage: Everyone should have the ability to pay for their health care services. No American should ever lose sleep over the possibility their coverage may be dropped if they become sick or change jobs.
- o Choice: People should have the option to choose the kind of coverage and the kind of providers that meet their particular needs.
- o Quality: Everyone should have care and treatment by the best health care professionals -- selected on the basis of need, not cost.
- o Innovation: We believe developing innovative new cost-effective technologies and treatments is critical to increasing the quality of care and to reducing costs.

ACCESS VS. COVERAGE

The distinction between access and coverage is an important one. Access means having quality care available at an affordable price. Coverage means you have insurance and the peace of mind of knowing you can pay for health care. The goal of reform should be to promote both. In the idealized health care system, they go hand in hand. Coverage is meaningless if you cannot find a doctor to treat you or if the quality of care is poor. Similarly, access to the best health care system in the world doesn't offer much if you cannot afford it.

We must make sure that health care reform doesn't sacrifice one for the other. The President has said he wants reform to guarantee everyone private health insurance that can never be taken away. In order to achieve this goal without a broad-based tax, the Clinton plan relies on price controls and government regulations. But if these controls and regulations put at risk our high quality care, universal coverage would be a Pyrrhic victory at best. In too many places, particularly inner city and rural areas, people who have coverage are still unable to see a doctor. What good is insurance coverage if there are inadequate facilities in the community or if there are long waits for treatment?

Reform should make coverage affordable and accessible to everyone. The first step should be to remove the barriers to coverage -- health status, income and employment -- that are responsible for 38 million Americans being uninsured. The employment barrier could be eliminated by creating purchasing pools for small businesses and individuals, giving them the same purchasing power large businesses now enjoy. No employer could be refused access to an affordable plan. Also, coverage could be made portable and guaranteed renewable and include some form of community rating. The income barrier could be eliminated by providing subsidies for low-income individuals on a sliding scale basis. And health barriers could be eliminated by preventing insurers from denying coverage to those with pre-existing conditions, or dropping coverage when someone files a claim. All applicants could be guaranteed an affordable health policy.

Eliminating these barriers would provide coverage to a significant majority of the uninsured. No American would be without coverage because of income, health or employment. The remaining uninsured could then be identified and targeted solutions developed to provide them coverage. This could be done by 1998 -- the same timetable set by the President. Such a strategy would fix the 15 percent of the system that is broken without totally disrupting the 85 percent that works well.

We do not believe an employer mandate combined with regulatory alliances is a good solution. It would allow government to dictate how businesses and individuals spend their resources and it could force businesses with small profit margins to freeze wages or lay-off workers. A Lewin-VHI study for the HLC found that an employer mandate is a clumsy way of providing universal coverage because it would provide subsidies to companies that already are able to afford coverage on their own.

INCREASING THE VALUE OF THE HEALTH CARE DOLLAR

Cost containment is vitally important. For too many people, health care is becoming too expensive. It is depleting family savings, driving up business expenses and increasing government budget deficits. But cost containment is ultimately about value. It is inaccurate for some to suggest we are paying more and more for less and less care. We are paying more and more for greater and greater care.

The question is not just how much we pay but whether we are getting our money's worth. The United States spends a lot on health care -- 14 percent of GDP. But would the American people rather spend half that amount if the quality of care was similarly cut in half? How much is too much? And how quickly can we reduce our national health spending without negatively impacting quality?

The goal of cost-containment should be to get the most value out of every health care dollar spent. This means increasing efficiency by reducing administrative costs, eliminating unnecessary procedures, reforming the malpractice system and revising anti-trust regulations.

LOOKING AT THE ALTERNATIVES

We believe all of these reform proposals -- Cooper/Grandy's "Managed Competition Act of 1993" (HR 3222), Chafee/Thomas's "Health Equity & Access Reform Today Act" (HR 3704), Nickles/Stearns's "Consumer Choice Health Security Act" (HR 3698), Michel/Lott's "Affordable Health Care Now Act" (HR 3080) and Ms. Johnson's "Health Plan Purchasing Cooperative Act" (HR 3652) -- contain provisions consistent with the principles of the Healthcare Leadership Council.

The Healthcare Leadership Council advocates insurance reforms. All these proposals would implement insurance reforms to make coverage portable and to prohibit insurers from denying coverage to those with pre-existing conditions or dropping coverage when you become sick -- making them compete in the market based on service, not risk selection.

The HLC advocates using market competition, not government regulations, to contain costs. Cooper/Grandy and Chafee/Thomas would contain costs by providing tax deductions only for the most cost-effective health plans, which would give consumers an incentive to choose the highest-quality, lowest-cost health plan. Competing for consumers would give providers incentives to operate more efficiently. Nickles/Stearns would replace current tax deductions with tax credits, thereby allowing consumers to shop for the most cost-effective health plans.

The HLC endorses small group purchasing pools. Most of these bills acknowledge the merits of purchasing groups. They also believe participation in purchasing pools should be restricted to those whom it was originally intended -- small businesses and individuals. Purchasing pools would give small businesses and individuals the same purchasing power larger businesses now enjoy. They also would cut down on administrative costs, which can be 35

percent more for small businesses and individuals, without burdening big business with unnecessary solutions. The Cooper/Grandy bill would require small businesses (those with fewer than 100 employees) to join purchasing cooperatives while Chafee/Thomas would make participation voluntary. Michel/Lott would set standards and incentives for group purchasing.

The Healthcare Leadership Council believes health care coverage can be affordable and accessible to all without an employer mandate. All these proposals seek universal access to coverage without using an employer mandate. They use a combination of subsidies or tax credits, insurance reforms and purchasing groups. Cooper/Grandy would immediately eliminate barriers to coverage and would achieve universal coverage by 1998 without a mandate. HR 3222 would require businesses to offer coverage to their employees but not necessarily pay for it. Chafee/Thomas would use an individual mandate to guarantee coverage, but subsidies would be phased in by 2005 and would be dependent upon achieving projected savings. Nickles/Stearns, meanwhile, would require everyone to purchase at least catastrophic coverage. Chafee/Thomas, Nickles/Stearns and Michel/Lott would all offer Medical Savings Accounts.

AREAS OF CONSENSUS

A look at all the reform proposals on the table reveals a remarkable degree of agreement. Everyone agrees health costs need to be contained and access to care expanded. There is also agreement on many of the ways of achieving these goals. Virtually all plans advocate insurance reforms, a basic benefits package, purchasing pools, consumer information, administrative and malpractice reform, subsidies and changes in the tax code.

As we debate the differences in these proposals, we must keep in mind there are more areas of agreement than disagreement. The HLC believes a bipartisan consensus can be forged. It is essential for successful passage and implementation of reform that support comes from both parties. We hope members of Congress will be able to tell their constituents next fall that they passed legislation that makes health care affordable and accessible to all while maintaining the quality, choice and innovation people expect.

Thank you for giving me the opportunity to speak with you.

Chairman STARK. Thank you.
Mr. Knettel, proceed.

**STATEMENT OF ANTHONY J. KNETTEL, DIRECTOR, HEALTH
POLICY THE ERISA INDUSTRY COMMITTEE**

Mr. KNETTEL. Thank you, Mr. Chairman. I am testifying today on behalf of the ERISA Industry Committee, which is an association of 120 of the country's largest employers.

In the interest of time, I will skip to page 2 of my statement if you are interested in following along with the written text.

ERIC's board of directors recently took several days to analyze in depth each of the following bills: H.R. 3080, H.R. 3222, H.R. 3600 which I will occasionally refer to for comparative purposes, H.R. 3698, and H.R. 3704.

Chairman STARK. Do for me what I do when I read Consumer Reports auto recommendation. I get right to the last page, so I don't have to read about all those cheap American cars, and I find out which good foreign car they are going to recommend. Which one of these plans did you pick?

Mr. KNETTEL. Frankly, Mr. Chairman, the board concluded that none of the bills adequately address the needs of major employers.

Chairman STARK. OK. Well, go ahead.

Mr. KNETTEL. I think the important information is in the details of what particular pieces of the bills posed problems.

I would like to very briefly summarize both the positive aspects that the board found in each of these bills, as well as some of the troubling aspects.

For example, the Michel-Gingrich bill recognizes a need to address a number of specific factors that contribute to the high cost of health care. It preempts State benefit mandates, antimanaged care laws, antiutilization review laws, and so forth.

The Cooper-Grandy bill recognizes the need to improve the quality and the cost effectiveness of health care delivery, and it attempts to do so by forming a marketplace where providers can be held accountable for their performance.

The administration bill recognizes that employers who currently provide voluntary coverage to employees, dependents, and early retirees bear a disproportionate share of national health care costs.

The Stearns bill recognizes that the health care system can never operate at optimal efficiency unless everyone is in the system.

The Thomas bill recognizes the need for employers to maintain control of the health care they purchase on behalf of employees and dependents.

So each of these bills, taken together, make important contributions to the debate and together include many, though not all of what we believe are the necessary elements for successful reform.

On the other hand, each bill has clear deficits as well, and I would like to very briefly summarize some of those for you. All of the bills examined, including the administration bill, lacked in one or more areas uniform Federal rules governing the organization and operation of the reformed health care marketplace. Uniformity is essential to ensure consistent health care quality and cost effectiveness throughout the system. In addition, Federal preemption of inconsistent State laws attempting to regulate employer-sponsored

benefit plans is essential for major employers to offer and maintain their health plans. This was of particular concern under the Stearns bill, for example, which would subject all employer-sponsored health plans to 50 different State insurance laws.

Second, the Cooper-Grandy bill, like the administration bill, would impose a specific combination of community rating, open enrollment, and prospective individual risk adjustment on the private marketplace. ERIC is not confident that either of these bills' versions of managed competition can be fully implemented without causing excessive instability in the reformed marketplace and an unacceptable number of insolvencies among both health plans and purchasing groups.

Third, under several of the proposals, employers would not be able to exert a sufficient degree of control over their financial liabilities, or the quality and cost effectiveness of health care they finance. Major employers in this country are in the vanguard of both effective cost containment and the encouragement of high-quality, cost-effective care, and to the degree they lose control over the care they finance, we are turning our backs on some of the most effective innovators within the health care system.

This was a particular concern under the administration bill, which gives States both the option to implement single-payer systems as well as the option to form regional alliances as State agencies.

Finally, to conclude, all of the bills institutionalize in one form or another cost-shifting in a number of areas, and the ERIC board was particularly concerned that each bill failed to adequately ensure that Medicare would purchase health care on the basis of the same market principles that would be applicable to private purchasers. It simply doesn't make sense to have one portion of the marketplace purchasing care in one way and having the rest of the marketplace purchasing it differently with a different set of incentives.

Chairman STARK. So you are suggesting I take cost controls off Medicare?

Mr. KNETTEL. I am suggesting that what we need is an integrated health care system with uniform incentives throughout the system.

Chairman STARK. Should there be cost controls or not cost controls? That is their choice. We have cost controls on Medicare. You put us all in the same system, we have a choice, either something besides cost controls, which then takes the wraps off Medicare, or put cost controls on everybody. There are only two sides to that coin.

Mr. KNETTEL. Mr. Chairman, I think there is a third alternative which is to move Medicare in the direction of greater utilization of capitated payments which puts—

Chairman STARK. I am not arguing with you. I am just saying right now 90 percent of Medicare is under cost controls on hospitals and doctors. It is a matter of your choice which one of all these plans you would prefer, but I happen to agree with you that we ought to have the same system or you have some problem of cost-shifting. You want to stop cost-shifting.

Now, I am asking you. You have a choice. I am giving you the choice, Mr. Knettel. Take cost controls off Medicare, and then, if you are wrong, your payroll tax is going to go through the roof, which is all right with me because I just raise it and you guys pay it. We will just put more on the employer than the employee, but we will do it. Or, we put everybody under some kind of a Medicare-like system, and we control cost of the private and public side. You don't have any other choice.

You want to bet the store that managed competition will hold your payroll tax where it is? Be careful.

Mr. KNETTEL. I think managed competition as defined in the Cooper bill or in the administration bill would not be a bet that our members would be willing to take; but they believe there are other forms of market competition, the ones that they engage in in their voluntary purchasing groups—

Chairman STARK. You go back. I like that your board is willing to accept whatever they want to accept, take the controls off Medicare and we pay what the market demands under whatever kind of structure you want to put on the private market, and your members will pay the increased payroll tax necessary to fund the entitlement cost to Medicare. I will wait for that day.

Just think it over, and send me your board's thoughts.

Mr. KNETTEL. Well, the members of the board have thought about it, and they believe that part of the problem that Medicare has had in containing its cost is the structure of the benefit and the fee-for-service payment system, to begin with. So, if we don't change that benefit structure within the program, I think there is a very real problem. But I think the problem is the result not just of the payment methodology or the cost controls, I think the problem is the structure of the underlying benefit.

Chairman STARK. You have got a choice. I am just saying you have one shot at the apple here, and I am willing to play that game with you. I think it is highly risky, but I am secure in the fact that your board would recognize the dangers in that.

Mr. KNETTEL. They also recognize the dangers of the current system where—

Chairman STARK. Good.

Mr. KNETTEL [continuing]. Tens of billions of dollars have been shifted to them on an annual basis.

Chairman STARK. Just giving you the choice, there is no middle ground if you are talking about Medicare. Now, you can do anything you want on the private side, but, frankly, I don't care. You can triple the cost of insurance to General Motors. It doesn't bother me one iota, but you be careful. When I am spending the taxpayers' money, I am not so willing to do that.

[The prepared statement follows:]

Written Statement for the Hearing Record
Subcommittee on Health, Committee on Ways and Means
U.S. House of Representatives
February 10, 1994

Anthony J. Knettel, Director, Health Policy
on behalf of The ERISA Industry Committee

REFORMING THE HEALTH CARE SYSTEM:
ERIC's Analysis of Reform Proposals

The ERISA Industry Committee (ERIC)¹ submits to the Subcommittee on Health, Committee on Ways & Means, the following testimony regarding the impact of selected health care reform proposals on employer-sponsored health benefit plans.

BACKGROUND

ERIC believes that improving the quality, cost-effectiveness, and accessibility of the current health care system in our country demands focused structural and financial reforms to address its deficiencies. Health care providers must be accountable to third-party payers and consumers for both the quality of their performance and the cost-effectiveness of the services provided. Reform must produce greater value for health care expenditures by improving the consistency and quality of care while managing cost.

Failure to reduce expenditures in real terms jeopardizes the affordability of health care coverage, reduces the number of people covered, and undermines the productivity and competitiveness of American businesses. The success or failure of reform proposals cannot be measured solely in terms of federal budget savings. Any measure of success or failure must take into account the impact of reform on the quality, as well as the cost-effectiveness, of health care delivery in both the private and public sectors. It must also take into account the impact of reform on those who pay for it, those who consume it, and those who provide health care services.

ERIC consistently has articulated a broad consensus among major employers that the keys to making health care affordable for all Americans are, first, a commitment to improve the way health care is organized and delivered with respect to both quality and cost, and second, a commitment to eliminate the cost-shifting that plagues current health care financing. ERIC's March 1993 *Policy Statement on Comprehensive Health Care System Reform*² states that significant reform of the current health care system is needed and should be consistent with these general principles:

- *A public-private partnership* encompassing payers, providers and consumers to design and implement reform;

¹ ERIC is a non-profit employer association committed to the advancement of the employee retirement, health, and welfare benefit plans of America's major employers. ERIC represents the employee benefits interests of more than 120 of the nation's largest employers. As sponsors of health, disability, pension, savings, life insurance, and other welfare benefit plans directly covering approximately 25 million plan participants and beneficiaries, ERIC's members have a strong interest in the success and expansion of the employee benefit plan system in the private sector. All of ERIC's members provide comprehensive health care coverage to their employees. Together, they provide coverage to about 10 percent of the U.S. population.

² Copies of ERIC's *Policy Statement* can be obtained by writing to The ERISA Industry Committee, 1400 L Street N.W., Suite 350, Washington DC 20005 or calling 202-789-1400.

- *A comprehensive strategy* for making the health care system coherent, efficient and cost effective;
- *An opportunity for employers* to voluntarily continue to be the primary source of health care coverage for their employees and their employees' dependents; and
- *Exclusive federal authority* over a national health care policy.

The following ERIC analysis is based on these four general principles of reform, as well as the specific market-based reforms that are articulated in the *Policy Statement*.

ANALYSIS

1. Bills Reviewed:

ERIC's Board of Directors has reviewed the following proposals, which are analyzed in this statement:

- the Michel-Gingrich bill (H.R.3080);
- the Cooper-Grandy and Breaux-Durenberger bills (H.R.3222 and S.1579, respectively);
- the Administration bill (H.R.3600/S.1757);
- the Nickles and Stearns bills (S.1743 and H.R.3698, respectively); and
- the Chafee and Thomas bills (S.1770 and H.R.3704, respectively).

ERIC continues to oppose single-payer health care reform proposals, whether they would establish a unified national single-payer system or individual state-by-state single-payer systems. ERIC believes that employers must retain control over any health benefits they help finance in order to manage their financial liabilities. In addition, ERIC believes that single-payer systems, in practice, are too inflexible and bureaucratic to fulfill the commitment to improve the quality and cost-effectiveness of health care delivery that is embodied in the health plans sponsored by major employers. Therefore, ERIC's analysis did not include the McDermott bill (H.R.1200) or other similar bills that have been introduced during the 103rd Congress.

2. General Assessment:

Each of the bills reviewed recognizes, either explicitly or implicitly, one or more of the principles and strategies for reform articulated in ERIC's *Policy Statement*. For example:

- The *Michel-Gingrich* bill recognizes the need to address a number of specific factors contributing to the high cost of health care. It preempts state mandated benefit, anti-managed care and anti-utilization review laws, and it includes small group insurance market reforms and medical malpractice reforms.
- The *Cooper-Grandy/Breaux-Durenberger* bills recognize the need to improve the quality and cost-effectiveness of health care delivery. They seek to create a marketplace where health care providers can be held accountable for their performance with respect to both quality and cost. Under the current health care system, where health care is often financed on a piece-work, fee-for-service basis, there is insufficient accountability.
- The *Administration* bill recognizes that employers that currently provide voluntary coverage to employees, dependents and early retirees, or that voluntarily provide prescription drug coverage to Medicare-eligible retirees, bear a disproportionate share of national health care costs. It seeks to distribute the burden of financing health care more broadly across the economy and to achieve universal coverage.

- The *Nickles/Stearns* bills recognize that the health care system can never operate at optimal efficiency unless all individuals participate in the system. They impose a significant tax penalty on taxpayers who do not obtain health insurance.
- The *Chafee/Thomas* bills recognize the need for employers to maintain control over the health care they purchase on behalf of employees and dependents. They provide for voluntary private group purchasing arrangements, building on the important contributions already being made by employer-led coalitions that have emerged in more than 90 locations around the country.

We believe the introduction of each bill has been an important contribution to the health care system reform debate. Taken together, these five bills contain among them many of the necessary elements of successful health care system reform.

Each of the bills also has deficits, however, either in the manner in which certain key issues are addressed or in the failure to address certain key issues at all. When each bill was measured individually against the criteria set out in ERIC's *Policy Statement*,³ none of the alternative bills examined was deemed to adequately address the interests and concerns of major employers.

In general, each of the bills (in its present form) raises one or more of the following concerns:

- All of the bills lacked, in one or more areas, uniform federal rules governing the organization and operation of a reformed health care marketplace that are essential for major employers to offer and maintain their health benefit plans.
- All of the bills institutionalize, rather than reduce, cost shifting in one or more areas, including cost shifting from the public sector to the private sector. In addition, some of the bills fail to address cost shifting that results from the failure to achieve universal coverage.
- Employers would not be able to exert a sufficient degree of control (direct or indirect) over their financial liabilities, or the value (*e.g.*, quality and cost-effectiveness) of the care they purchase, under several of the proposals.
- ERIC is not confident that adequate data and technology are currently available to implement the system of broad community rating, open enrollment and prospective risk adjustment called for under some of the bills without potentially causing unacceptable instability in the marketplace.
- Financing schemes under several of the bills fail to address adequately or realistically the costs created by the bills.

3. Bill-by-bill Assessment:

The following bill-by-bill assessments delineate the strengths and weaknesses of each bill in five areas that are essential to successful reform.

a. Nationally uniform rules and standards.

For major employers, which generally have employees geographically dispersed in multiple states, uniformity in the rules governing health reform is a very high priority. Moreover, health care is among our biggest industries in interstate commerce. Major employers believe that to the degree the health care system is regulated at all, it must be subject to nationally uniform rules and standards to assure the quality and consistency of

³ ERIC's *Policy Statement* is summarized in an appendix at the end of this statement.

care throughout our health care system, and the common treatment of employees of the same employer.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich*: The bill increases uniformity in some areas relative to current law by preempting counterproductive state laws that interfere with the development of cost-effective health plans.
- *Cooper-Grandy/Breaux-Durenberger*: The bills increase uniformity in some areas relative to current law by preempting counterproductive state laws that interfere with the development of cost-effective health plans, but potentially erode uniformity in other respects. For example, granting states discretion in organizing health plan purchasing cooperatives and certifying accountable health plans would likely result in an undesirable degree of inconsistency from state-to-state.
- *Administration*: The bill erodes uniformity by providing excessive discretion to states in implementing regional alliance structures and in exercising the option to form single-payer systems. Financial incentives and administrative complexities are so heavily weighted against forming a corporate alliance that the advantage of limited federal preemption of state law afforded to corporate alliance sponsors is not enough to make forming a corporate alliance a viable option for most major employers. Thus, such employers effectively would be forced into state-run regional alliances -- bureaucratic state government agencies with all their attendant problems and deficiencies.
- *Nickles/Stearns*: The bills erode uniformity by making all employer health plans, including self-insured plans, subject to state insurance laws. Model insurance reforms contemplated by the bills do not appear to guarantee state-to-state consistency.
- *Chafee/Thomas*: The bills erode uniformity for insured health plans by subjecting them to state regulation, but largely preserve uniformity for self-insured plans by subjecting them to federal regulation.

Recommendation: ERIC urges that any bill favorably reported by the Committee provide that federal law preempts any and all relevant state laws to preclude state discretion and ensure there will be national uniformity in all rules and standards that apply to how the health care system in general, and employer-sponsored health plans and purchasing groups in particular, will be organized and operated.

b. Eliminating cost shifting.

In the current health care system, ERIC member companies bear a disproportionate share of health care costs compared with other payers, particularly with respect to coverage of employed spouses who are not offered or who decline coverage from their own employers, coverage for pre-Medicare eligible retirees, and cost shifting resulting from uncompensated care (*i.e.*, the uninsured) and undercompensated care (*i.e.*, from Medicare and Medicaid). Cost shifting distorts the health care marketplace and undermines its efficient operation. Thus, the reduction, if not elimination, of such cost shifting is a high priority for ERIC member companies.

ERIC's insistence on the elimination of cost shifting does not mean major employers are unwilling to contribute their fair share toward the cost of providing appropriate income-related public subsidies for the purchase of health care. To ensure that there is public accountability for the amount and financing of such subsidies, however, at a minimum: (1) any such subsidies must be explicit (*i.e.*, not merely built into the structure of health care premiums), and (2) any taxes or other surcharges

imposed on employers to help finance the cost of such income-related subsidies must be explicit (*i.e.*, not merely built into the structure of health care premiums) and must be imposed on all payers.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich*: The bill does not address cost shifting.
- *Cooper-Grandy/Breaux-Durenberger*: The bills do not directly address cost shifting attributable to employed spouses, or the expense of voluntary coverage for early retirees. In some cases, the bills appear to make cost shifting a permanent part of the structure of health care premiums. For example, by including current Medicaid beneficiaries in the same purchasing cooperative premium pool as private payers, the bills effectively shift part of the cost of financing coverage for such persons from general revenues to a per capita percent-of-premium tax on employment. The Medicare at-risk contract adjustment payment mechanism institutionalizes a cost shift from the federal government to "closed" as well as certain "open" accountable health plans. To the degree general Medicare cuts are used to finance the bills, cost shifting to private payers will worsen.
- *Administration*: The employer mandate reduces current cost shifting from employers that do not offer employees coverage to employers that offer family/dependent coverage, and partially reduces the cost to employers of providing pre-Medicare eligible retiree health coverage. On the other hand, by including current Medicaid beneficiaries in the same regional alliance premium pool as private payers, the bill effectively shifts part of the financing of such persons from general revenues to a per capita percent-of-premium tax on employment. By providing subsidies only to employers participating in regional alliances, and by imposing percent-of-payroll taxes on employers forming corporate alliances, the bill institutionalizes cost shifts to corporate alliance sponsors, particularly those that have cost-effective plans. To the degree general Medicare cuts are used to finance the bill, cost shifting from that source will worsen.
- *Nickles/Stearns*: Tax incentives for individuals to purchase coverage may reduce cost shifting to some extent, but many forms of cost shifting remain.
- *Chafee/Thomas*: The individual mandate reduces cost shifting to some extent, but other forms of cost shifting remain. To the degree Medicare cuts are used to finance the bills, cost shifting will worsen.

Recommendation: ERIC urges that any bill reported favorably by the Committee ensure that every individual who does not receive health care coverage either (1) from a government program, or (2) from an employer by virtue of being an employee or a non-employed spouse or dependent, obtains such coverage from a federally sanctioned privately operated purchasing group. Any taxes or surcharges to finance subsidies should be explicit (*i.e.*, not built into the premium structure) and apply to all payers. In addition, all government health care programs should be required to purchase health care coverage using the same market competition mechanisms that private purchasers use and fund the full cost of such care.

c. Employers' control over their financial liabilities.

Because major employers have a long history of purchasing health care for large groups of employees, they have the greatest expertise, and have achieved the greatest success, in maximizing the value of the health care coverage purchased. Anyone who pays a substantial portion of the cost of health care coverage is entitled to and needs control over what and how it is purchased in order to control the payer's financial

liabilities. Therefore, maintaining a strong employer influence over health care coverage purchasing decisions is a high priority for major employers.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich*: The bill does no apparent significant harm to the degree of employer control; it improves employer control to the extent it preempts state laws that interfere with employers' plan design decisions (*i.e.*, preempts state mandated benefit laws, anti-managed care or anti-utilization review laws, etc.).
- *Cooper-Grandyl/Breaux-Durenberger*: Although the bills limit all employers' control over plan design by specifying a uniform set of effective benefits, they otherwise largely preserves employer control over health coverage purchasing decisions (such as which health plans to contract with) for those employers that remain outside health plan purchasing cooperatives. Employers that are required to purchase care through such cooperatives retain some influence over the operation of the cooperative itself -- by virtue of the fact that they are organized as nonprofit entities, rather than state agencies or quasi-private entities run by a board of political appointees as under the Administration bill -- but they do not retain direct control over purchasing decisions.
- *Administration*: The bill erodes employer control over plan design and purchasing decisions. In addition to dictating a plan's scope of coverage, its cost-sharing features, and the mandatory inclusion of a fee-for-service option, the bill subjects all employers to state discretion as to whether to establish a state-based single-payer system, and subjects employers participating in regional alliances (the vast majority of businesses) to state discretion as to whether to operate such alliances as state agencies or as quasi-private entities dominated by political appointees. Even employers forming corporate alliances are subjected to significant constraints, including requirements to offer three types of coverage even if an employer's experience has demonstrated that one or more types of coverage provide inferior value.
- *Nickles/Stearns*: Although employers are not directly constrained by federal law under these bills, employer control of both plan design and purchasing decisions would still be eroded by virtue of the fact that all employer plans would be subject to state insurance laws. States historically have sought to undermine employer discretion through a variety means: mandated benefit laws interfering with plan design and protecting health care provider special interests; anti-utilization review and anti-managed care laws; and taxing benefit plans. Although some of these avenues are foreclosed to states under the bills, others are not; states will continue to undermine employer discretion by every means made available to them under these bills.
- *Chafee/Thomas*: The bills' benefit package requirements place constraints on plan design, but employers generally retain full discretion with respect to purchasing decisions due to the voluntary nature of purchasing groups and the employer's role.

Recommendation: ERIC urges that any bill favorably reported by the Committee ensure that no employer is required to participate in a purchasing group that is operated as a government agency or that is run by political appointees. Further, to the degree that plan design is constrained at all -- for example, by requiring that employers offer (but not necessarily contribute to the cost of) health care coverage, employers must still retain the flexibility to set the specific employer and employee cost sharing features of such coverage and to retain the option to offer actuarially equivalent benefits.

d. Financial stability of the reformed marketplace.

ERIC believes that health care reform must have as a primary goal changing the way health care is organized and delivered. A prerequisite for improved health care delivery is a more coherent and efficient health care marketplace.

Changes in the marketplace are dependent on available data and information technology, however. Forcing the marketplace to operate in a fundamentally different way than it does today, on the basis of inadequate data or immature information technologies, could result in market volatility great enough to cause serious financial harm (including insolvencies) to health plans or purchasing groups. Market-based reforms must not be abandoned because they are essential to successful reform generally; but they should be implemented cautiously, in stages where necessary, to minimize disruption.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich*: The bill does little to destabilize the marketplace, but also does little to directly improve the quality and cost-effectiveness of health care delivery.
- *Cooper-Grandy/Breaux-Durenberger*: Arguably, no one currently knows how to set age-banded, community-rated premiums in the context of both (1) unstable enrollment due to the elimination of barriers to free movement between health plans, and (2) prospective adjustments to payments made to accountable health plans based on the health risk posed by individual enrollees. Even if adequate data were currently available, which it is not, it is debatable that a single generalized risk adjustment formula can be developed that will work in health markets with disparate utilization patterns, demographic composition, and other relevant differences. Moreover, if the financial pressure of an aggressive tax cap is added, as under these bills, the marketplace volatility that could result from near-to-immediate transition to the regulated market contemplated by these bills may produce an unmanageable number of accountable health plan and health plan purchasing cooperative insolvencies.
- *Administration*: The same concerns exist regarding the Administration bill as those expressed regarding the Cooper-Grandy/Breaux-Durenberger bills, because at its core this bill is based on very similar community rating, open enrollment and risk adjustment requirements. The transition to the new principles is a little slower relative to Cooper-Grandy/Breaux-Durenberger, but the principles would be applied to a far greater proportion of employers and individuals. Market instability (*i.e.*, health plan and regional alliance insolvencies) may be increased by the financial pressure added by the bill's requirement that a surcharge be imposed on health plans that exceed budget limits, which is another completely new risk that must be taken into account when determining what premium to bid.
- *Nickles/Stearns*: Though they would remove barriers to movement between competing health plans, there is little reason to expect that this alone would destabilize the marketplace as a whole. The bills are likely to do little to change health care delivery or improve its cost-effectiveness, however, because the bills encourage individual choice based on product differentiation (*i.e.*, the scope of coverage and cost-sharing features) rather than the cost-effectiveness of health care delivery.
- *Chafee/Thomas*: The voluntary nature of purchasing groups and the voluntary adoption of prospective risk adjustment mechanisms, coupled with reliance on community rating within age bands rather than pure community rating, appear to mitigate the potential for instability in the operation of health care markets. The long-term effectiveness of this approach in improving the quality and cost-

effectiveness of health care delivery depends on the emergence of specific effective strategies from the marketplace itself, a grass-roots approach that is likely to be more responsive to the needs of purchasers and providers, as well as less disruptive, than more rigid proposals.

Recommendation: ERIC urges that any bill that is favorably reported by the Committee strongly encourage group purchasing on a capitated basis, implement consensus insurance market reforms, and provide for the voluntary adoption by employer-led private purchasing groups of specific strategies to improve market competition (such as prospective risk adjustment and related techniques) at an appropriate point in time, rather than prematurely imposing such strategies on the marketplace before they are fully developed.

e. Credibility of financing provisions.

Since health reform legislation inevitably has an impact on federal expenditures and the federal deficit, major employers view any financing provisions with well-founded skepticism. To be blunt, in the current budgetary environment, the benefits of various bills are often overstated and the costs are often understated or hidden. Health reform is no exception. ERIC members are particularly concerned that underfinanced health reforms, based on overly optimistic revenue estimates, could ultimately impose far greater than expected liabilities on employers.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich:* The bill does not require a significant amount of financing relative to other bills.
- *Cooper-Grandy/Breaux-Durenberger:* Revenues to be raised from a cap on deductible employer health benefit expenses may be overstated since employer behavior will be hard to predict. For example, employers are likely to respond by seeking to shift/recharacterize their expenditures into other deductible expenses (e.g., wages). In addition, the cap will increase the cost of providing coverage for employers that voluntarily provide comprehensive benefits. Medicare savings may be partially offset to the degree such Medicare cuts cause cost shifting to the private sector, which in turn may result in increased deductible private employer expenditures.
- *Administration:* Financing is so complex that there is little likelihood that needed dollars can flow smoothly and efficiently from multiple sources to multiple destinations without shortfalls and windfalls along the way. The high probability that very few large employers will find forming a corporate alliance financially viable could substantially alter the expected mix of revenues to be generated by the percent-of-payroll tax on corporate alliance sponsors as compared to other revenue sources (including community-rate premiums). Medicare savings may be partially offset to the degree such Medicare cuts cause cost shifting to the private sector, which in turn may result in increased deductible private employer expenditures.
- *Nickles/Stearns:* The difficulty in predicting individual behavior in light of radical transformation of the tax treatment of health coverage (from income exclusion to tax credit) makes financing uncertain. Capping federal Medicaid payments could result in cost shifting, further distorting revenue estimates.
- *Chafee/Thomas:* Revenues to be raised from tax caps may be overstated due to the difficulty of predicting changes in employer and individual behavior caused by restructured tax incentives. Medicare and Medicaid savings may be partially

offset by increased deductible private expenditures to the degree such cuts cause cost shifting to the private sector.

Recommendation: ERIC urges that any bill that is reported favorably by the Committee ensure that neither tax caps on the deductibility of employer health benefit expenses nor Medicare/Medicaid cuts are relied on as financing mechanisms. Further, any financing burden imposed on employers should not materially differ solely on the basis of an employer's decision to join or not join a purchasing group.

CONCLUSION

ERIC asserts that successful health care system reform will respond to the following needs:

- Improving accountability for the quality of health care and the outcome of treatment;
- Improving the efficiency of the health care marketplace by encouraging cost-effective group purchasing (through employer-led private purchasing coalitions) under uniform federal rules and standards;
- Allocating resources and financing burdens equitably throughout the entire economy, including the elimination of cost shifting; and
- Providing for a transition strategy that minimizes disruption in the marketplace.

By this standard, none of the bills under consideration is completely successful.

ERIC supports market-based strategies for health care system reform that preserve the discretion of employers and the autonomy of employer-sponsored health benefit plans, and have as their primary goal increased accountability for both the quality and cost-effectiveness of care. The members of ERIC represent a tremendous reservoir of experience and expertise regarding these issues. We look forward to the opportunity to work toward these goals with the Congress and the Administration generally, the Committee, and each of the individual bill sponsors.

* * * * *

APPENDIX

To summarize ERIC's position on reform as articulated in its March 1993 *Policy Statement*, ERIC supports health care system reform that:

- Is implemented in a comprehensive rather than a piecemeal fashion; but may be implemented in stages to minimize disruption.
- To the extent that regulation of health care delivery is necessary, provides for exclusive federal regulation rather than state-by-state regulation.
- Restructures health care delivery through organized groups of providers, driven aggressively and competitively by multiple group purchasers, to produce a marketplace that encourages continuous improvement in provider performance and cost containment.
- Creates federally sanctioned local and regional purchaser-controlled health care coverage purchasing groups, whose mission includes identifying undercapacity and overcapacity and allocating resources more efficiently; and allows employers to act as

stand-alone purchasers or form consortia with other employers that remain outside purchasing groups.

- Reduces aggregate health care expenditures as a prerequisite to expanding access to health care.
- Retains employers' ability to deduct the cost of health care coverage as an ordinary business expense.
- Preempts state regulation of employer-sponsored health plans, including but not limited to current state benefit mandates, state anti-managed care laws and state anti-utilization review laws.
- Rejects short- or long-term cost containment mechanisms that fail to promote delivery reform or that interfere with market reforms intended to encourage changes in the current delivery system.
- Requires both quality and price competition among health care providers.
- Develops specific criteria for evaluating health care provider performance (*e.g.*, measurable outcomes, quality and patient satisfaction) so that the quality of health care can be measured and improved over time.
- Creates a federal health care standards body to articulate uniform, consistent and compatible standards for the collection of provider performance, quality and cost data, and to foster the development of uniform claims forms, electronic claims filing standards, and similar administrative efficiencies.
- Equitably shares the financial burden of providing universal access to care among all payers in a manner that eliminates cost shifting from uncompensated and undercompensated care.
- Subjects Medicare, Medicaid, and other government health programs to the same market and financing reforms as private sector health care coverage.
- Requires that individuals who otherwise would be without coverage (from a voluntary employer-provided health plan or from a government program) obtain health care coverage from a purchasing group.
- Reforms the insurance market; and reforms tort and malpractice laws to reduce the cost of claims appeals and litigation and eliminate unreasonable awards.
- Preserves uniform federal rules regarding health benefit plan fiduciary standards, claims dispute resolution procedures, and other plan administration standards -- which currently preempt any state efforts to regulate these aspects of employee benefit plan administration; applies these same federal rules to all care purchased under the reformed federal framework.

Chairman STARK. Mr. Van Dongen.

**STATEMENT OF DIRK VAN DONGEN, COCHAIRMAN,
HEALTHCARE EQUITY ACTION LEAGUE, AND PRESIDENT,
NATIONAL ASSOCIATION OF WHOLESALE DISTRIBUTORS**

Mr. VAN DONGEN. Good afternoon, Mr. Chairman. It is a pleasure to be here at these obviously important hearings. It has been a long day, sir, for the committee. I will be brief.

I would simply like to make five summary points and then get to whatever questions you might wish to have me and other members of the panel entertain.

First, HEAL is an employer-based coalition. Over 1 million employers are represented. We are a pro-health care reform group. We came together in 1991 during the then-Bush administration for the purpose of encouraging them as well as the Congress to move forward with a results-oriented health care reform.

In part, this committee is responsible for the existence of HEAL in that part of the catalyst for its creation was the Ways and Means Committee retreat on health care at West Point in which I and some of the others involved in putting HEAL together were privileged to participate.

Second, I think it is important that you know that HEAL supports universal coverage. As a practical matter, we believe universal coverage is necessary to achieve the solutions to the problems that the employers in our coalition face in providing health care to their employees.

Third, we have concluded, and, frankly, this was not even a close call, that we cannot support the President's plan. It is simply the wrong path to reform, in our view, and we don't—

Chairman STARK. Can you support his goals?

Mr. VAN DONGEN. Very definitely.

Chairman STARK. OK.

Mr. VAN DONGEN. I don't think there is much debate, indeed, in the Congress or about the land with regard to the goals that the President has set forth. We don't support his plan because we don't believe that mandates, price controls, spending caps, mandatory alliances are the right way to go. We think they add up to excessive government intervention and fear that they may well produce what is aptly been described by some as kind of a fatal cure.

Fourth, I think it is a legitimate question. Having said that, so what do we support? We have listed several key elements in our written statement which collectively we believe will send us well along the path to results-oriented reform. They are based upon market forces. We believe they fix what needs fixing while preserving what is right in our current system.

Fifth and to the point of these hearings, many of the major alternative reform plans, including those crafted by some of the members of this subcommittee, contain many of the reform initiatives which HEAL endorses. We have consistently urged and urge the Congress again to act on these consensus measures now, not necessarily as a grand and final solution where the issue will never be revisited, but, rather, to begin to bring relief now as opposed to the possibility of engaging in protracted, contentious battle, which

when all is said and done may result in a circumstance where, unfortunately, reform of any type is forestalled this year.

Mr. Chairman, thank you, and will try to respond to any questions.

[The prepared statement and attachments follow:]

February 10, 1994
Statement of:

Dirk Van Dongen
Co-Chairman, Healthcare Equity Action League (HEAL)
President, National Association of Wholesaler-Distributors (NAW)

Before the:

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

On:

HEALTHCARE REFORM:
ALTERNATIVE HEALTH REFORM PROPOSALS

INTRODUCTION

Mr. Chairman, Congressman Thomas, members of the Subcommittee, my name is Dirk Van Dongen. I am President of the National Association of Wholesaler-Distributors (NAW). NAW is composed of individual wholesale distribution firms and a federation of 114 national commodity line associations and regional, state and local associations and their member firms which, collectively, total more than 45,000 companies.

NAW serves as the Executive Secretariat of the Healthcare Equity Action League (HEAL), a coalition of 630 companies, associations and organizations, representing over 1 million employers and in excess of 25 million employees nationwide. HEAL was created in 1991 for the purpose of encouraging the then Bush Administration and the Congress to act quickly to reform the healthcare system utilizing free enterprise, market-based principles. I appear before you today on behalf of both HEAL and NAW.

Mr. Chairman, you and the Subcommittee are to be commended for your commitment to healthcare reform and your willingness to explore alternatives to the President's healthcare reform legislation.

Let me first speak on behalf of HEAL.

THE PRESIDENT'S HEALTH SECURITY ACT

While the President is to be commended for bringing the critical issue of healthcare reform to the legislative forefront, HEAL cannot support the President's Health Security Act. Simply stated, we have serious concerns about its funding, scope, and cost.

Specifically, we are opposed to the following key provisions of the President's bill:

Mandates on employers to pay the cost of coverage for all employees and their dependents will inevitably result in the loss of jobs, predominantly from those who can least afford it;

Price caps and global budgets are misguided attempts to control costs, avoid the real causes of medical inflation, and have never worked in modern history. Pure and simply, they both will cause rationing;

Mandatory health alliances that force almost all Americans into huge, heavily regulated, monopolistic government purchasing groups will not help, but will only add another costly and ineffective layer of government bureaucracy between individuals and their medical care;

Excessive government intervention, in a structure not unlike that in a single payer system, has never simplified or reduced costs and will only serve to institutionalize many of our current problems;

The plan is administratively burdensome and extraordinarily complex, compelling employers to be involuntary administrators for a massive new government program; and

Employers would lose virtually all control over their employee health benefit programs and the money they spend on them. They will be relegated to little more than check writers and form filers for the government to determine their employee benefit plans.

AN ALTERNATIVE REFORM AGENDA

The over 630 members of the Healthcare Equity Action League (membership roster attached) came together to support free enterprise, market-based healthcare reform. HEAL believes strongly that health system reform can be achieved without exerting excessive federal control over prices, plans, premiums, physicians and patients; in short without federal preemption of the free market in healthcare.

HEAL urges Congress to:

Reform insurance practices to prohibit the abuse of preexisting condition clauses, guarantee renewability and portability, provide for a more equitable rating system, and encourage the creation of voluntary, nonregulatory pooling mechanisms for individuals and small business;

Assist those who cannot afford to purchase insurance coverage;

Reject employer mandates;

Reject price controls and global budgets;

Inject cost-consciousness into our health insurance decisions by limiting the tax deductibility and tax exclusion of employer-sponsored health benefits;

Level the playing field for self employed businesses by increasing the deductibility of health insurance premiums from 25% to 100%;

Reform our medical liability laws to reduce costly defensive medicine and ease resolution of malpractice disputes;

Disseminate cost and quality data to assist consumers in making more cost-conscious choices; and

Lower health administrative costs by standardizing claims forms and encouraging electronic filing.

HEAL's approach has been to lay out a set of principles that we believe should characterize effective, results-oriented health reform. As such, HEAL has not officially endorsed any specific proposal. We do believe, however, that with the exception of the single payer bill, each of the major alternative reform measures contains positive provisions that will control insurance costs and increase access to coverage. Indeed, many of the reform items supported by HEAL are contained in major alternative proposals, including:

- The Health Equity and Access Reform Today Act (S. 1770/H.R. 3704), introduced by Senator Chafee and Representative Thomas;
- The Managed Competition Act (H.R. 3222/S.1579), introduced by Representatives Cooper and Grandy, and Senators Breaux and Durenberger;
- The Affordable Health Care Now Act (H.R. 3080/S. 1533), introduced by Republican Leader Michel and Senator Lott;

- The Consumer Choice and Personal Health Security Act (H.R. 3698/S. 1743), introduced by Representative Stearns and Senator Nickles; and
- The Health Plan Purchasing Cooperative Act (H.R. 3652), introduced by Representative Johnson.

Healthcare reform is essential; a federal takeover of the healthcare system in the name of reform is not. Congressional and public support is widespread for the reforms outlined above. The Congress has an historic opportunity to ensure true healthcare security and stability by reforming -- not replacing -- our healthcare system. HEAL will continue to work to change what is wrong with our system and preserve what is right.

Obviously, Mr. Chairman, in my capacity at NAW, I am most familiar with the experiences of the wholesale-distribution industry. And, as I stated when I testified before the full committee in October of 1991, our overwhelming problem is rooted in cost. While the vast majority of wholesaler-distributors (over 97 percent) provide health insurance coverage to their employees, the spiraling increases in premiums which have occurred over the past few years have represented a higher and higher percentage of overall compensation and have forced our members to reevaluate this vital employee benefit. Some have restructured their health insurance plans; others have reduced benefits or increased their employees' share of premium costs. Companies who operate with very narrow margins -- and wholesaler-distributors do -- are finding it more and more difficult to maintain affordable healthcare plans which deliver comprehensive and high quality coverage to their employees.

Yet, our industry has told us again and again that they do not believe that government control, like that envisioned in the President's Health Security Act, is the answer. I said it in 1991, and I will say it here again, it is our view that a healthcare system run from Washington would inevitably result in lower quality care at higher prices. Nothing in our national experience suggests that the Federal government could -- or should -- effectively regulate one-seventh of our economy; approximately \$1 trillion in healthcare spending annually.

Mr. Chairman, in October of 1993, we asked our members to tell us what impact the Health Security Act would have on their health insurance cost. Fully seventy percent of the respondents reported that their costs would increase under the Clinton Plan. Similarly, in that same month, in our quarterly NAW Confidence Index Survey, we asked "What impact do you expect the Clinton Administration healthcare proposals to have on your business?" Seventy-nine percent answered "Negative," sixteen percent responded "Neutral," and only five percent said the proposals would have a positive effect.

Last week, NAW held its Annual Meeting here in Washington. After considering the reform proposals currently on the table, our members made it clear that they favor prompt passage of bipartisan legislation which addresses those issues on which a consensus has emerged, such as guaranteed coverage, renewability, portability, limits on pre-existing condition exclusions, administrative simplification and medical malpractice reforms. These elements exist in the President's legislation and in almost all other major alternative bills. In our view, such legislation could pass Congress quickly and would represent meaningful and effective healthcare reform with minimum government intervention. Simply stated, Mr. Chairman, let us fix now what is widely viewed to be broken--knowing that we can revisit these, and other, issues if necessary in the future.

Finally, NAW is most encouraged by the efforts being undertaken in the Congress to package and pass the reform items on which a strong consensus exists now. Legislation is being drafted by Representatives Rowland and Bilirakis. There is a similar bill in the Senate. And, former Senator Bentsen succeeded in securing Senate passage of a similar bill twice in the last Congress. Mr. Chairman, it is NAW's position that, at least as a beginning, we ought to take the consensus items I listed above and pass them today. We believe these would go a very long way toward bringing costs down and therefore increasing access to coverage for millions of Americans.

CONCLUSION

Mr. Chairman, thank you for allowing me to testify before you today. HEAL and NAW will continue to promote enactment of the reform items outlined above and hope to see Congress pass healthcare reform this year. We look forward to working with the Committee on these critical issues, and will be happy to take any questions you may have.

ATTACHMENT:

HEAL Membership Roster

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)**STEERING COMMITTEE**

Actna Life & Casualty	National Council of Chain Restaurants
American Association of Preferred Provider Organizations	National Council of Community Hospitals
American Home Products Corporation	National Federation of Independent Business
American Hotel & Motel Association	National Medical Enterprises, Inc.
American Managed Care & Review Association	National Restaurant Association
American Portland Cement Alliance	National Retail Federation
AMGEN Inc.	National Wholesale Druggists' Association
Amway Corporation	Olsen Kimberly QualityCare
Associated Builders and Contractors	PepsiCo
Associated Equipment Distributors	Pharmaceutical Manufacturers Association
Association for Suppliers of Printing and Publishing Technologies	The Prudential
Blue Cross of Western Pennsylvania	Schering-Plough Corporation
Bristol-Myers Squibb	ServiceMaster Management Services
Burger King Corporation	Shoney's, Inc.
Burroughs Wellcome Company	Society of American Florists
Cancer Treatment Centers of America	SYNTEX (U.S.A.), Inc.
The CIGNA Corporation	The Travelers Companies
Council of Smaller Enterprises	Wendy's International, Inc.
The Doctors' Company	Western Growers Assurance Trust
The Donnelly Group	
DynCorp	
Electronics Representatives Association Insurance Trust (Chicago, IL)	
Eli Lilly & Company	
Epic Healthcare Group (Dallas, TX)	
Evanston Hospital Corporation	
Federation of American Health Systems	
Food Marketing Institute	
General Mills Restaurants, Inc.	
The Grand Union Company	
Group Health Association of America	
Harman Management Corporation	
Harris Methodist Health System	
Health Industry Distributors Association	
Health Industry Manufacturers Association	
Health Midwest	
HealthSpan	
Healthcare Leadership Council	
Hillcrest Baptist Medical Center	
Humana Inc.	
John Hancock Mutual Life Insurance Company	
The Law Offices of Deborah Steelman	
Marriott Corporation	
McDonald's Corporation	
Metropolitan Life Insurance Company	
Midwestern Regional Medical Center	
Morrison Incorporated	
National-American Wholesale Grocers' Association	
National Association of Aluminum Distributors	
National Association of Convenience Stores	
National Association of Temporary Services	
National Association of Wholesaler-Distributors	
National Committee for Quality Health Care	
National Council of Agricultural Employers	

ATTACHMENT

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)

GENERAL MEMBERSHIP

- Accounting By Computer (Bend, OR)
 Adami & Co. Independent Insurance Agency (Rock Falls, IL)
 Adirondack Regional (NY) Chambers of Commerce
 Addison (IL) Association of Industry & Commerce
 Advertising Specialty Institute
 Aerospace Industries Association
 Air-conditioning & Refrigeration Wholesalers Association
 Alabama Hospital Association
 Alabama Wholesale Beer & Wine Association
 The Alan White Co., Inc. (Stamps, AR)
 Albertson's, Inc.
 Allatoona Sod (Kennesaw, GA)
 Allen Construction Inc. (Lawrence, KS)
 Allen Park (MI) Chamber of Commerce
 Alliance of American Insurers
 The Aluminum Association
 Ambler & Hickerson, Inc. (Dallas, TX)
 American Apparel Manufacturers Association
 American Association of Nurserymen
 American Concrete Pipe Association
 American Council on Education
 American Cyanamid Company
 American Electronics Association
 American Federation of Small Business
 American Furniture Manufacturers Association
 American Hardware Manufacturers Association
 American Health Care Association
 American Machine Tool Distributors Association
 American Meat Institute
 American Paper Institute
 American Rental Association
 American Society of Computer Dealers
 American Society of Travel Agents
 American Supply Association
 American Traffic Safety Services Association
 American Veterinary Distributors Association
 American Wholesale Marketers Association
 Americans for Intelligent Health Care Reform
 AMI Twelve Oaks Hospital (Houston, TX)
 Anderson Remodeling & Maintenance (Roscoe, IL)
 Ann's Flowers (Yoakum, TX)
 Appliance Parts Distributors Association
 A.R. Vetter Co. (Rebersburg, PA)
 Arcadia (OH) Superette
 Ardmore (OK) Chamber of Commerce
 Arizona Restaurant Association
 Arnett & Company Health Communications
 Associated Beer Distributors of Illinois
 Associated General Contractors
 Associated Landscape Contractors of America
 Association of Commerce and Industry (MI)
 Association of Floral Importers of Florida
 Association of Ingersoll-Rand Distributors
 Association of Steel Distributors
 Atkinson (IL) Veterinary Service
 ATLAND Management Corporation (Pleasantville, NJ)
 Atlanta (GA) Chamber of Commerce
 Automotive Parts Rebuilders Association
 Automotive Service Industry Association
 Aviation Distributors & Manufacturers Association
 Baker Industries, Inc.
 Bankers Life & Casualty
 Baptist Medical Center of Oklahoma
 Beauty & Barber Supply Institute
 Becton Dickinson & Company
 Beer & Wine Association of Ohio
 Beer Industry League of Louisiana
 Beer Industry of Florida
 Beer Wholesalers Association of New Jersey
 Bellevue (WA) Chamber of Commerce
 Beltone Hearing Aid Center (Odessa, TX)
 Bismarck-Mandan Area (ND) Chamber of Commerce
 Benefit Design Group, Inc.
 Benihana National Corporation
 Berghoff Restaurant Company
 Bicycle Wholesale Distributors Association
 Bill Jayson & Company (Dallas, TX)
 Biscuit & Cracker Distributors Association
 Bismarck-Mandan Area (ND) Chamber of Commerce
 Dr. Donald G. Blain, M.D.
 Blochs Restaurants Inc. (Bellevue, WA)
 Bob Chinn's Crabhouse Restaurant (Wheeling, IL)
 Boon-Chapman
 Boulder (CO) Chamber of Commerce
 Braintreeboro Area (VT) Chamber of Commerce
 Brookside Properties, Inc. (Nashville, TN)
 The Business Council of New York State, Inc.
 California Association of Tobacco & Candy Distributors
 California Association of Wholesalers-Distributors
 California Beer & Wine Wholesalers Association
 California Trucking Association
 Cambe Geological Services, Inc. (Houston, TX)
 Carl Karcher Enterprises
 Carlsbad (CA) Chamber of Commerce
 Carroll Auto Parts, Inc. (Big Spring, TX)
 Carroll County (MD) Chamber of Commerce
 Cars & Stripes, Ltd. (Cleburne, TX)
 Carson City (NV) Chamber of Commerce
 Casa Ole, Inc. (Houston, TX)
 Case Management Society of America
 Central Louisiana Chamber of Commerce
 Central Wholesalers Association
 Century Office Systems (Austin, TX)
 Ceramic Tile Distributors Association
 Chamber of Commerce of Auburn and Cayuga (NY) County
 Chamber of Commerce of Hawaii
 Chamber of Commerce of New Rochelle (NY)
 Chamber of Medford/Jackson County (OR)

- Champaign County (IL) Chamber of Commerce
 Charles M. Ostheimer & Associates, Inc. (Alpharetta, GA)
 Cheektowaga (NY) Chamber of Commerce
 Chenango County (NY) Chamber of Commerce
 Chicago Metropolitan Distributors Association
 Chicago Tastee Freez Corporation
 Chillicothe-Ross (OH) Chamber of Commerce
 Chocolate Manufacturers Association
 Christian Booksellers Association
 Clarks Petroleum Service Inc. (Canastota, NY)
 Cleaning Equipment Trade Association
 Clemson Area (SC) Chamber of Commerce
 Clinton (MS) Chamber of Commerce
 Colorado Restaurant Association
 Colorado Springs (CO) Chamber of Commerce
 Commerce and Industry Association of New Jersey
 Computing Technology Industry Association
 Copper & Brass Servicenter Association
 Corporate Mailing Concepts (Louisville, KY)
 Council for Periodical Distributors Association
 The County (NY) Chamber of Commerce, Inc.
 CPI Benefits Inc. (Morristown, NJ)
 Crawford Fitting Company
 Creare Inc. (Hanover, NH)
 CutCo Industries, Inc. (Jericho, NY)
 Dahl Certified Public Accountants (Lowell, IN)
 Dairy and Food Industries Supply Association
 Danville Area (VA) Chamber of Commerce
 Davenport (IA) Chamber of Commerce
 Diagnostic Support Services, Inc.
 Dietz Construction (Findlay, OH)
 Direct Selling Association
 Douglas Area (WY) Chamber of Commerce
 Eagle Creek Resort, Inc. (Northfield, IL)
 Earth Resources Corporation (Ocoee, FL)
 The East Concord (NY) General Store
 Eastern Land Management, Inc. (Shelton, CT)
 Eckerd Drug Company
 Electrical Apparatus Service Association
 Electrical-Electronic Materials Distributors Association
 Ellis Insurance Agency (Hobbs, NM)
 Employee Benefits South, Inc. (Atlanta, GA)
 Employee Managed Care Corporation
 Engine Service Association
 Environmental Technologies Group, Inc. (Baltimore, MD)
 Eric Denton Inc. (Pana, IL)
 Essex County (MA) Chamber of Commerce
 Everett (MA) Chamber of Commerce
 Express Visa Service, Inc.
 Fairway Health Insurance Services (Ventura, CA)
 Farm Equipment Wholesalers Association
 First Maryland Bancorp (Baltimore, MD)
 F.L. Roberts & Co., Inc. (Springfield, MA)
 Florida Restaurant Association
 Florists' Transworld Delivery Association
 Fluid Power Distributors Association
 Folk's Folly Prime Steak House
 Food Industries Suppliers Association
 Food Processing Machinery and Supplies Association
 Foodmaker, Inc.
 Foodservice Equipment Distributors Association
 Friend Laboratory, Inc. (Waverly, NY)
 Gail F. Piltz Inc/DBA Comprehensive
 Accounting (Indianapolis, IN)
 Gainesville-Hall County (GA) Chamber of Commerce
 Gastonia (NC) Chamber of Commerce
 General Merchandise Distributors Council
 Georgia Beer Wholesalers Association
 Georgia Chamber of Commerce
 Gladstone (MO) Chamber of Commerce
 Glenwood Springs (CO) Chamber Resort Association
 Goldendale (WA) Chamber of Commerce
 Grand Rapids Area (MI) Chamber of Commerce
 Greater Austin (TX) Chamber of Commerce
 Greater Baton Rouge (LA) Chamber of Commerce
 Greater Bethesda-Chevy Chase (MD) Chamber of Commerce
 Greater Carlisle Area (PA) Chamber of Commerce
 Greater Detroit Chamber of Commerce Wholesaler-Distributor
 Association
 Greater Florence (SC) Chamber of Commerce
 Greater Fort Myers Beach Area (FL) Chamber of Commerce
 Greater Fulton (NY) Chamber of Commerce, Inc.
 Greater Iberia (LA) Chamber of Commerce
 Greater Kansas City (MO) Chamber of Commerce
 Greater Lafayette (IN) Chamber of Commerce
 Greater Martinsville (IN) Chamber of Commerce
 Greater North Dakota Association/WAM Council
 Greater Ohare (IL) Association
 Greater Omaha (NE) Chamber of Commerce
 Greater Paradise Valley (AZ) Chamber of Commerce
 Greater Raleigh (NC) Chamber of Commerce
 Greater Riverside (CA) Chamber of Commerce
 Greater Seattle (WA) Chamber of Commerce
 Greater Syracuse (NY) Chamber of Commerce
 Greater Valley (CT) Chamber of Commerce
 Greater Waco (TX) Chamber of Commerce
 Greater Washington Food Wholesalers
 Greenscape Inc. (Holly Springs, NC)
 GTE North (Noblesville, IN)
 Guest Services, Inc.
 Gwinnett (GA) Chamber of Commerce
 Hackettstown (NJ) Chamber of Commerce
 Hampshire House
 Hampton Roads (VA) Chamber of Commerce
 Hardee's Food Systems, Inc.
 Hastings Area (NE) Chamber of Commerce
 Health Care Partners, Inc. (San Antonio, TX)
 HealthTrust, Inc.
 Henderson (NV) Chamber of Commerce
 Hershey Foods Corporation
 Hiawatha Resort (Wetmore, MI)
 Hobby Industry Association of America
 Hoffmann-La Roche Inc.
 Holiday Inn Worldwide
 Home Health Care
 Hospital Corporation of America

Hospitality Association of South Carolina
Howard County (MD) Chamber of Commerce
Huntington Beach (CA) Chamber of Commerce
Illinois Restaurant Association
Illinois Valley Area Chamber of Commerce
The Image Producers, Inc. (Canfield, OH)
Independent Bankers Association of America
Independent Electrical Contractors, Inc.
Independent Medical Distributors Association
Independent Sealing Distributors
Independent X-ray Dealers Association
Indiana Beverage Alliance
Indiana Restaurant Association
Indianapolis (IN) Chamber of Commerce
Indianapolis Newspapers, Inc.
Industrial Distribution Association
Insurance Administration Center, Inc. (Tampa, FL)
Insurance Association of Connecticut

The Interior Plant Company (Houston, TX)
International Association of Amusement Parks and Attractions
International Association of Plastics Distributors
International Dairy Foods Association
International Hand Protection Association
International Hardware Distributors Association
International Truck Parts Association
International Sanitary Supply Association
International Wholesale Furniture Association
Iowa Benefits, Inc. (Ames, IA)
Iowa Grain and Feed Association
Iowa Restaurant & Beverage Association
Irrigation Association
Jack Faucett Associates, Inc. (Bethesda, MD)
Jackson (MS) Chamber of Commerce
Jeffersontown (KY) Chamber of Commerce
Jeffrey Contracting (Prescott Valley, AZ)
Jewelry Industry Distributors Association
JLC, Inc. (Littleton, CO)
Jobbers Credit Association
John M. Regan & Associates, Inc. (Metairie, LA)
John L. Wortham & Son, L.L.P. (Houston, TX)
Johnson & Johnson
Johnson City Medical Center Hospital (Johnson City, TN)
JT&A, Inc.
Juneau (AK) Chamber of Commerce
Kansas Chamber of Commerce & Industry
KC Enterprises (Las Vegas, NV)
Keach & Grove Insurance, Inc. (Bedford, IN)
Kenosha Area (WI) Chamber of Commerce
Kentucky Restaurant Association
Ketler Forlines, Inc. (Gaithersburg, MD)
Ki-Star Group of Texas, Inc.
The Krystal Company (Chattanooga, TN)
Kyana Industrial Supply (Louisville, KY)
L&L Landscape Services Inc. (Santa Clara, CA)
Lake Champlain (VT) Regional Chamber of Commerce
Lancaster (TX) Chamber of Commerce
Landscape Design & Construction, Inc. (Grand Junction, CO)

Lavonia (GA) Chamber of Commerce
LeGro & Associates (Mount Vernon, WA)
Lenert Plumbing, Inc. (Naperville, IL)
Lenoir County (NC) Health Cost Containment Coalition
Lettuce Entertain You
The Levy Organization (Chicago, IL)
Londontown Corporation (Eldersburg, MD)
Long John Silver's, Inc.
Los Angeles Fasteners Association
Louisiana Restaurant Association
Louisville Area (KY) Chamber of Commerce
Machinery Dealers National Association
Maine Restaurant Association
Malcolm Thompson, Magaro & Associates (Houston, TX)
Maneval, Inc. (Jasper, MO)
Manitowoc-Two Rivers (WI) Chamber of Commerce
Massachusetts Restaurant Association
Material Handling Equipment Distributors Association
McDonald's of Plymouth (WI)
McMann Giles & Associates Employee Benefits (Danville, VA)
MDU Resources Group, Inc. (Bismarck, ND)
MECCO (Medford, OR)
Medical Technology Development, Inc.
MedTrac, Inc. (Nashville, TN)
Meeker Sharkey Benefits (Cranford, NJ)
Melrose Diner, Inc. (Philadelphia, PA)
Memphis Area (TN) Chamber of Commerce
Mendota Area (IL) Chamber of Commerce
Merrill Quality Landscapes (Rexburg, ID)
Metro East (MI) Chamber of Commerce
Metro Newark (NJ) Chamber of Commerce
Metropolitan Milwaukee Association of Commerce
Michigan Association of Distributors
Michigan Beer & Wine Wholesalers Association
Michigan Distributors & Vendors
Michigan Restaurant Association
Mid-America Supply Association
Middle Atlantic Wholesalers Association
Miller & Loughry Insurance Services (Murfreesboro, TN)
Minnesota Beer Wholesalers Association
Minnesota Restaurant, Hotel & Resort Association
Mississippi Malt Beverage Association
Missouri Auction School (Kansas City, MO)
Missouri Beer Wholesalers Association
Missouri Restaurant Association
Monroe (LA) Chamber of Commerce
Montana Chamber of Commerce
Montgomery County Pharmaceutical Association of Pennsylvania
Morning Glory Dairy (DePere, WI)
Morton's of Chicago, Inc.
Motorcycle Industry Council
Mount Carmel (IL) Chamber of Commerce
Mount Vernon (NY) Chamber of Commerce
Music Distributors Association
National Appliance Parts Suppliers Association
National Association of Chemical Distributors

- National Association of Computer Consultants and Resellers
- National Association of Container Distributors
- National Association of Decorative Fabric Distributors
- National Association of Electrical Distributors
- National Association of Floor Equipment Distributors
- National Association of Floor Covering Distributors
- National Association of Flour Distributors
- National Association of Hose and Accessories Distributors
- National Association of Meat Purveyors
- National Association of Realtors
- National Association of Recording Merchandisers
- National Association of Service Merchandising
- National Association of Sign Supply Distributors
- National Association of Sporting Goods Wholesalers
- National Association of Wholesale Independent Distributors
- National Beer Wholesalers Association
- National Building Material Distributors Association
- National Business Forms Association
- National Business Owners Association
- National Club Association
- National Commercial Refrigeration Sales Association
- National Council of Agricultural Employers
- National Electronic Distributors Association
- National Fastener Distributors Association
- National Food Distributors Association
- National Frozen Food Association
- National Grocers Association
- National Industrial Glove Distributors Association
- National Insulation and Abatement Contractors Association
- National Lawn & Garden Distributors Association
- National Locksmith Suppliers Association
- National Marine Distributors Association
- National Office Products Association
- National Paint Distributors
- National Paper Trade Association
- National Poultry & Food Distributors
- National Sash & Door Jobbers Association
- National School Supply & Equip Assn
- National Solid Wastes Management Association
- National Spa & Pool Institute
- National Staff Leasing Association
- National Stone Association
- National Technical Services Association
- National Truck Equipment Association
- National Welding Supply Association
- National Wheel & Rim Association
- Nebraska Restaurant Association
- New Berlin (WI) Chamber of Commerce
- New England Wholesalers Association
- New Jersey Association of Temporary Services
- New Jersey Restaurant Association
- New York State Beer Wholesalers Association
- New York State Plumbing & Heating Wholesalers
- New York State Restaurant Association
- NMTBA-The Association for Manufacturing Technology
- North American Graphic Arts Suppliers Association
- North American Horticultural Supply Association
- North American Wholesale Lumber Association
- Northamerican Heating, Refrigeration & Airconditioning Wholesalers
- North Carolina Beer Wholesalers Association
- North Carolina Restaurant Association
- North Carolina Wholesalers Association
- Northern Berkshire (MA) Chamber of Commerce
- Northern Rhode Island Chamber of Commerce
- Northwestern Public Service Company
- Ocala/Marion County (FL) Chamber of Commerce
- Odessa (TX) Chamber of Commerce
- Ohio Restaurant Association
- Oklahoma City (OK) Chamber of Commerce
- Oklahoma Restaurant Association
- Oklahoma State Chamber of Commerce & Industry
- Optical Laboratories Association
- Orange County (NY) Chamber of Commerce
- Oregon Restaurant and Hospitality Association
- Ott Enterprises Inc. (Norwalk, OH)
- Outdoor Power Equipment Distributors Association
- Pacific Automotive Trades Association
- Pacific Southwest Distributors Association
- Pasadena (CA) Chamber of Commerce
- PDC Multimedia Productions (Norman, OK)
- Pennsylvania Chamber of Business and Industry
- Pennsylvania Hospital
- Pennsylvania Restaurant Association
- Pet Industry Distributors Association
- Peterson Chemical Corporation (Sheboygan Falls, WI)
- Petroleum Equipment Institute
- Petroleum Marketers Association of America
- Pfizer Inc.
- Phenix City-Russell County (AL) Chamber of Commerce
- Pike County (KY) Chamber of Commerce
- Piscataway-Middlesex Area (NJ) Chamber of Commerce
- Pitt/Greenville (NC) Chamber of Commerce
- Plantmann Industries (St. Louis, MO)
- Plantscapes, Inc. (Seattle, WA)
- Pocono Mountains (PA) Chamber of Commerce
- Poor Boy's Riverside Inn (Lafayette, LA)
- Portland (OR) Metropolitan Building Owners and Managers Association
- Portland (OR) Visitors Association
- Positive Chimney Shoppe (Cadillac, MI)
- Podlatch Corporation
- Poughkeepsie Area (NY) Chamber of Commerce
- Power Transmission Distributors Association
- Primary Medical Clinic (Midland, TX)
- Printing Industries of America
- Produce Marketing Association
- Pueblo (CO) Chamber of Commerce
- Quincy Area (IL) Chamber of Commerce
- Rally's Inc.
- Ransdell Surgical, Inc. (Louisville, KY)
- Rapid City Area (SD) Chamber of Commerce
- Reno Sparks Convention and Visitors Authority
- Restaurant Association of Maryland
- Restaurant Association of the State of Washington, Inc.

Restaurant Enterprises Group, Inc.
 Restaurant Management Services
 Retail Bakers of America
 Rhode Island Hospitality Association
 Riverdale (NJ) Texaco
 Riverton (WY) Chamber of Commerce
 Rome Area (NY) Chamber of Commerce
 Rosenberg/Richmond Area (TX) Chamber of Commerce
 Rowan County (NC) Chamber of Commerce
 Safety Equipment Distributors Association
 Saint Paul Area (MN) Chamber of Commerce
 Santa Ana (CA) Chamber of Commerce
 Sarasota (FL) Chamber of Commerce
 Schererville (IN) Chamber of Commerce
 Schiffli Lace & Embroidery Manufacturers Association
 Schoch Tiles and Carpets (Cincinnati, OH)
 Scripps Memorial Hospitals
 Selfridge & Associates, Inc. (New Albany, IN)
 Shawnee (OK) Color Lab & Studio
 Shoe Service Institute of America
 The Sidwell Company (West Chicago, IL)
 Siler City (NC) Chamber of Commerce
 Simon Financial Company
 Small Business of America
 Snack Food Association
 Society of Professional Benefits Administrators
 South Carolina Beer Association
 South Dakota Restaurant Association
 South Pike Area (MS) Chamber of Commerce
 South Shore (MA) Chamber of Commerce
 Southern Wholesalers Association
 Southworth-Milton, Inc. (Milford, MA)
 Specialty Tools & Fasteners Distributors Association
 Spraying Systems Company (Wheaton, IL)
 St. Joseph Healthcare Group, Inc.
 St. Lawrence County (NY) Chamber of Commerce
 St. Lucie County (FL) Chamber of Commerce
 Star Administration Services, Inc. (San Antonio, TX)
 Steel Service Center Institute
 Stephen Fendos & Associates (Hayden Lake, ID)
 Sterling Winthrop Inc. (New York, NY)
 Storm Lake (IA) Chamber of Commerce
 Structural Concepts Corporation (Spring Lake, MI)
 Super Valu Stores, Inc.
 Superior Basement Water Control (Walnut Creek, OH)
 Suspension Specialists Association
 Swartz Restaurants Corporation
 Telecommunications Industry Association
 Tennessee Restaurant Association
 Terry Erickson Agency Inc. (Marshfield, WI)
 Texas Restaurant Association
 Textile Care Allied Trades Association
 Thomas Jefferson University Hospital (Philadelphia, PA)
 Thomson Gardens Inc. (Maineville, OH)
 Titusville Area (FL) Chamber of Commerce
 Topper Construction, Inc. (Spring Lake, MI)
 Traverse City Area (MI) Chamber of Commerce
 Tri-State Utility Products, Inc. (Marietta, GA)

Twinsburg (OH) Chamber of Commerce
 Unimax Hearing Instruments, Inc.
 Union County (NJ) Chamber of Commerce
 United Products Formulators & Distributors Association
 United Restaurant & Lodging Association
 United Telephone-Southeast (Bristol, TN)
 United Truck Body Co. Inc. (Duluth, MN)
 Utility/Property Abatement (Little Falls, NJ)
 Vegas Time Associates, Inc. (Sterling, VA)
 Vermont American Corporation (Louisville, KY)
 Virginia Chamber of Commerce
 Virginia Restaurant Association
 Walker Health Insurance Services, Inc. (Santa Ana, CA)
 Walker's Diesel Services (Houston, TX)
 Wallcoverings Association
 Warehouse Distributors Association for Leisure
 and Mobile Products
 Warren County (PA) Chamber of Commerce
 Waste Management Inc.
 Water Systems Council
 Waterloo (IA) Chamber of Commerce
 Water & Sewer Distributors of America
 R.E. Watson & Associates, Inc. (Kennedale, TX)
 Wauconda (IL) Chamber of Commerce
 Wausau (WI) Hospital Center
 Wellesley (MA) Chamber of Commerce
 Western Association of Fastener Distributors
 Western Suppliers Association
 White County (GA) Chamber of Commerce
 Wholesale Beer Distributors of Texas
 Wholesale Distributors Association
 Wholesale Florists & Florist Suppliers of America
 Wholesale Stationers' Association
 Wine & Spirits Wholesalers of America
 Wisconsin Restaurant Association
 Wisconsin Wholesale Beer Distributors Association
 Woodbridge (NJ) Metropolitan Chamber of Commerce
 Woodworking Machinery Distributors Association
 Woodworking Machinery Importers Association
 Workforce Inc. (Lake Orion, MI)

Chairman STARK. Let me try this on you. The idea of Medicare benefits are too generous is not worthy of debate.

Mr. VAN DONGEN. I am sorry, sir?

Chairman STARK. The idea that Medicare benefits are too generous doesn't wash. We have an obligation for 35 million people who are not going to get private insurance from anybody else because they won't offer it.

If some of these ideas prevailed and we took controls off Medicare, remember that since 1983 when we put in the DRG system, the rate of increase of Medicare spending for its beneficiaries has gone up at half the rate of private insurance in this country.

If we had not, let's just assume we privatized it. Then there would have been whatever the concomitant increase in the payroll tax would have been to fund Medicare because that is how we make it balance, and that is in the law. Medicare costs go up; you pay. Some is paid in general revenue, but the heavy part will come out of payroll taxes.

Now, I give you the same opportunity I gave Mr. Knettel. I understand that if we continue to control Medicare costs as we do with what you don't like, price controls, and premium caps, by the way, is also part of Medicare, interestingly enough, for a risk contract, we could take those off, and then we would be subject under an indemnity plan to pay all the bills, just like everybody else. My guess is we would start going up at the rate of private insurance increases, and that is one choice.

The other choice is for us to continue as we are, and then if there is, in fact, cost-shifting which would only occur if the private side can't keep the rates as low as we would have to keep them—and there is a lot of political pressure not to keep them. We just don't cut doctor's rates or hospital rates around here with a lot of aches. So I would suggest to you that we just don't blindly cut rates. It isn't that easy.

Is there any reason that your group, you think, would suggest that we take our cost containment program off Medicare?

Mr. VAN DONGEN. That has not been a matter of discussion, frankly, Mr. Chairman.

Chairman STARK. Think about it, and you let us know because I think what you are going to find then on the other side—and again I would like you to think about this and let me know what your group says—if we don't put some cost containments on the private side for the providers, then you could be subject to a lot of cost-shifting, and I am not suggesting that we set the rates, but I am suggesting that if there isn't a balance on the other side every time we hold down rates in Medicare, your members are going to pay for it, particularly if they have a bargained plan.

I wonder if we ignored putting a similar cost containment system on both sides of that equation, that private industry wouldn't be back here in a while saying please put cost controls on. I don't know that, but it makes sense to me that we ought to do it on the same basis.

Mr. Knettel, I think, agrees with that. He would just pick a different basis than I might.

Mr. VAN DONGEN. Mr. Chairman, if I could just comment, and I take your point. I don't purport to be an expert on Medicare, but

I do come from an industry where the employers, according to our statistics in 97 out of 100 cases, provide health care insurance to their employees and good coverage in the main.

What brings the National Association of Wholesaler Distributors to the issue is the issue of costs that are exploding in our member companies. Part of those costs, I believe, result from the provider community recovering from private employers what they do not feel——

Chairman STARK. Absolutely.

Mr. VAN DONGEN [continuing]. That they are getting out of the Federal Government.

Chairman STARK. Absolutely.

Mr. VAN DONGEN. That having been said, as we have looked at this whole issue——

Chairman STARK. There are only two ways to solve that, Mr. Van Dongen. Let the public payments go up, which means the taxpayers have to pay more for Medicare, or put some cost containment of one kind or another on the private side. I don't know. I mean, I think a third way——

Mr. VAN DONGEN. I guess, Mr. Chairman, where we might take a different path is not on whether cost containment is required. Clearly, in the case at least of the organization I represent, and I believe this is true for virtually the entire membership, if not the entire membership of HEAL as a coalition, cost is what brings us to the issue, and at the end of the day, we take the point and care very much about the fact that we haven't accomplished from our parochial perspective very much at all if we don't get our hands around the cost issue.

Where we would take a different path is that it is our considered view that we can best accomplish that objective over time through the utilization of competitive initiatives as opposed to matters that are imposed by fiat or approaches that are proposed by fiat.

Chairman STARK. I might try to prove that that is not as effective, but I agree with you that it must be there.

I am just suggesting to you that if the President's plan, for example, were to prevail or Cooper was to prevail, we would take the controls off of Medicare as well. Then I am saying if your idea doesn't work, you got a double ugly down side. That is all. I want you to think that one through.

I want to just ask Ms. Bailey very quickly and anybody else who has a solution. I know that Dr. Simmons has the right solution, and Ms. Shearer could be the independent referee here, but we have got a problem. We have 35 billion uninsured, and I could tell you that 70 percent of those are below two times the poverty, and that means they don't have enough money to buy much.

I can also tell you that in round figures there is not a plan in the land, whether it is the President's, whoever appraises it, or anybody else's where you are going to provide a relatively modest, much more modest than the President's, health care program with a lot of copays and a lot of out-of-pocket expenditures for less the \$2,000 a year. I mean, they just don't exist.

So we have a \$70 billion a year plan. Two-thirds of that, let's call it \$45 billion a year, give or take, depending on how many you think might pick up on it. Where do we get the money? Honestly,

let everything else along. Let Mr. Van Dongen's members do what they want. Go join in and bid with whomever they want. If we are going to meet the President's request, we have got somewhere between a \$40 and \$70 billion, I am going to suggest, shortfall. There will be a lot of savings, but they will go to Mr. Van Dongen's group, and we won't get the benefits back.

You take your savings in good health and expand the wholesale business, but my point is we don't get that. We only get the savings on the private side, and that ain't going to be enough. So I am saying absent any savings in Medicare from Mr. Knettel's new way to save costs, we are short. Where do we get it?

Ms. BAILEY. That is exactly the issue.

Chairman STARK. I will tell you some ideas.

Ms. BAILEY. Yes.

Chairman STARK. A point on the corporate tax would raise about 30. A point on the payroll raises about 30. Would you buy into that? That is what we are facing.

Ms. BAILEY. That is right.

Chairman STARK. That is what Reischauer brought to the table. There isn't a health fairy out there that is going to put this policy under our pillows, and if I am willing to call it a tax, call it a tax. It is all right with me. You can call it a premium if you want to. You can call it a mandated payment. The bottom line is I got to find, whatever those things are that you call them, \$45 or \$50 billion a year. Who has got it? Who wants to volunteer?

Ms. BAILEY. That is the issue that we spend a great deal of time talking about, and I want you to know we share that concern, and that is the same dollar amount.

Chairman STARK. What is the least objectionable?

Ms. BAILEY. Well—

Chairman STARK. Come on.

Ms. BAILEY. First of all, we have a study that Lewin-VHI did for us that we would be glad to make available to the committee that points out the subsidies based on an individual mandate system are a lot less expensive than an employer mandate because with an employer mandate, you end up subsidizing companies who don't need that subsidy. So it is targeted toward need.

We also support a tax cap.

Chairman STARK. Beg your pardon? A tax cap?

Ms. BAILEY. A tax cap.

Chairman STARK. That will raise it. That will also raise it about \$30 billion.

Ms. BAILEY. Then if you add a cigarette tax on top of that, you are beginning to—

Chairman STARK. But the tax cap comes out of Mr. Van Dongen's constituency. It is a tax cap on the corporations, and we figure actually about 16 billion out of corporate America on the cap.

Mr. VAN DONGEN. Mr. Chairman, our testimony specifically references the fact that the Coalition does, indeed, support—I repeat—support a tax cap. We do not come to that easily, quite obviously.

Chairman STARK. Yes.

Mr. VAN DONGEN. We come to that because we think that is perhaps the most effective device we can think of to cause business

and their employees to behave in a more consumerist manner as they interact with the health care system. We, too, have wrestled, in other words.

Chairman STARK. They would behave like——

Mr. VAN DONGEN. I am sorry, sir?

Chairman STARK [continuing]. They would behave like anguished apes on my side of the aisle where the tax cap, unfortunately, is politically unpopular.

Mr. VAN DONGEN. I understand that.

Chairman STARK. I am not sure they like the payroll tax any better, but I wonder what difference does it make outside of a philosophic concern. If corporation A gets a tax cap or 1 percent—in this case, a ½ percent on its corporate rate, we are talking \$16 billion there, either one. Outside of the fact that some people feel that you will make employees feel the difference, but there is a lot of evidence that they won't, that they won't respond. Very rich people might, but the average person needs what they need, and they don't figure out in the short run what the advantage and disadvantage is.

My theory is that once you are in for a tax, you are in for a tax, but I want to find out this. Ms. Bailey was going to get me \$45 billion here, a tax cap.

Ms. BAILEY. We talked about a tax cap on both the employer and the employee because we think it is important that neither be immune to the incentives that we are talking about here.

I guess the other point is that this is exactly the point that we hoped the public debate would focus on because there is no free lunch, and there is agreement we need to subsidize.

Chairman STARK. What do you do about the employer who doesn't give any benefits? What do you do with McDonald's, Marriott, Nordstrom, and the rest of those fair-minded folks who don't pay any benefits? A tax cap doesn't make any difference to them. Mr. Van Dongen's buddies all pay and his customers don't, and they ain't going to buy more——

Ms. BAILEY. Well, I will let Mr. Van Dongen speak for the small employer, but it is our understanding that most small employers want to provide coverage.

Chairman STARK. Let me give you a May 1992 NFIB study, and they sent it to all the Members of Congress. They tell us about the people in our districts. NFIB, May 1992, I know this fits indelibly in my mind. Would you, it says, support being required to provide health insurance to your employees even if you had to pay none of the cost? Sixty percent said no.

I know. I said what do you do with those guys, and I suppose the reason is they don't want government. They don't want to be told. Whatever their reason, I am going to tell you that our polls, and the NFIB hasn't been here to testify, they don't want to have anything to do with it.

Ms. BAILEY. If I could say, though, I think that probably is a reaction to the mandate and general issue of government mandates. I think part of what has happened is the total lack of faith in the insurance system as it serves the small employer market today.

Chairman STARK. Or government.

Ms. BAILEY. That is right, but we know through insurance reforms how to restore some of that. That is where we think many of these small employers who have experienced cherrypicking and have suffered at the hands of this will come back into the market and provide coverage once they have an affordable plan.

Dr. SIMMONS. Mr. Chairman, we understand the concern about mandates, but at the same time, some of the proponents of other approaches rely so much on managed competition. The fact is that managed competition, as described by the theorists who developed it, can't work unless you have universal coverage, and they also require an employer mandate. Now, you can't get there from here.

If you believe in managed competition, then you have got to have universal coverage, and if you go by what the proponents did, it has to have an employer mandate. I think that is an important thing for those who feel that way to grapple with.

Chairman STARK. The middle ground, I suppose, is managed care which says you can compete if you want or not want. I mean, it is not quite as onerous, but I don't think that deals with our universal coverage thing.

We are sort of in the box. Ms. Bailey faced up to it with us. We are talking \$45 or \$50 billion a year, and it ain't going to be any fun. We don't have any volunteers, and, quite frankly, none of us like to be the leader. I don't want to go down in the 13th Congressional District as the leader of the guy who wants to put x pennies a gallon on their gas tax or their income tax or anything else, if I can avoid it, but I don't think avoiding it gets the universal coverage. That is the box I am in.

The cost controls, we all agree. I think the question is which ones will work. If I can figure out, first of all, where to get the money for the uninsured or the people who may become uninsured, and then you will have States opt out. If a State wants to have single payer, if a State wants to have managed competition, be my guest. We got a \$45, \$50 billion a year problem, and we don't have any volunteers, and that—

Mr. GOLDBERG. Mr. Chairman.

Chairman STARK. Mr. Goldberg, are you going to pay?

Mr. GOLDBERG. Pardon me?

Chairman STARK. Are you going to offer to pay?

Mr. GOLDBERG. Not personally, but I did want to make two points. One is that, as you know, roughly 84 percent of the uninsured are either in the work force or in families that include a member of the work force.

Chairman STARK. Two-thirds of them are below two times the poverty. These people are the people who are working for McDonald's.

Mr. GOLDBERG. The point I wanted to make first is that if we had an employer mandate, conjoined with an individual mandate, much of the money that is needed to provide universal coverage would come through the employers.

Chairman STARK. Oh, you have got no quarrel with me. All right. I have got a solution. Dr. Simmons is absolutely right. You have got to have both, basically.

Mr. GOLDBERG. Second, as to the residual, I just wanted to make it clear that the members of our Coalition, when they developed

their strategy, agreed to and proposed a one percent payroll tax to be split between employers and employees to cover the remaining cost.

Chairman STARK. I will tell you how you can do it. I probably learned this from Dr. Simmons. It gets dangerously close to the old pay or play. The \$2,000 we talked about, it is \$1 an hour, 80 cents on the employer, 20 cents on the employee. You add 90 cents increase to the minimum wage in 1991 and 1992, and nobody went broke because of it.

Mr. VAN DONGEN. Our industry pays substantially above minimum wage.

Chairman STARK. I know. So you wouldn't be affected. I am just saying you treat this mandate, if you don't have insurance for your employees, you don't pay the buck, if you are one of those people. If you are Zoe Baird, it is a \$1 an hour, 20 cents out of her babysitter, 80 cents out of her husband's pocket, and that is the dollar. 1 hour or 10, you pay, and that will raise some money and be an employer mandate for those who don't have insurance elsewhere in some program they choose to purchase. That still leaves us a bit short, probably another \$30 billion short, and that is where your 1 percent payroll tax picks it up a little bit more on the deductibility than I think you want. We need a half-a-percent and the deductibility. There aren't enough cigarettes in the world to do it.

Mr. VAN DONGEN. Mr. Chairman, something else that might make a contribution is to ensure that the Congress does not include in any health reform package you pass the buy-out for early retirees, which to us makes absolutely zero sense. It is counterintuitive.

Chairman STARK. You are absolutely——

Mr. VAN DONGEN. In a day and age where we are worried about people living too long——

Chairman STARK. It is a gift to the people who need it least.

Mr. VAN DONGEN. It helps downsize corporate America with folks that are 55 years of age or over.

Chairman STARK. Great minds go in the same direction, Mr. Van Dongen.

Mr. VAN DONGEN. Thank you.

Chairman STARK. There is no question. No, sir. I don't know where that one came out of the woodwork, but no thanks.

Mr. McCRERY. Briefly, Mr. Chairman, Ms. McCaughey testified on an earlier panel. She made reference to an article that she has written for the next issue of the New Republic. We have an advanced copy of that, and she would like to have that included in the record. So, with unanimous consent, I would request that unanimous consent that her article be included in the record, without objection.

Thank you, Mr. Chairman.

[The article appears after Ms. Caughey's written statement on page —:]

Mr. McCRERY. I thank all of you for coming today. I am sorry I wasn't here for all of your testimony, but I have seen parts of your written testimony, and I agree with much of what many of you have said.

I don't know if you were here earlier. I am in the process of trying to tie up all the loose ends on my health care bill, and it in-

cludes some of the things that you have talked about. I have a brief summary I would like to pass out to you, and if any of you have comments or suggestions, I will probably take another couple of weeks before I finish writing it, but it includes many of the incentives that you all have talked about in trying to get control in the private sector on cost, as well as expanding access to the system by providing tax credits, refundable tax credits to low-income folks without mandates, without employer mandates.

I am still considering the question of an individual mandates, but, anyway, I will give this to you, and if you have any comments, I would appreciate it.

Chairman STARK. Thank you very much.

This hearing is adjourned.

[Whereupon, at 3:50 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Health Insurance Market Reform

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Excerpted from *Reforming Private Health Insurance*, AEI Press: forthcoming 1994.

This statement comments on the health care reform bills considered at the February 10, 1994 hearing by the House Ways and Means Subcommittee on Health. The focus is on small-group market reforms, community rating, and voluntary purchasing cooperatives.

Small-Group Market Reforms

The package of proposals labeled as small group market reform, although complex and industry driven, for the most part make good sense and have been well received in the states in which they were first enacted. However, their very limited ambition must be kept clearly in mind. Guaranteed issue, insurance portability, rate compression, reinsurance, purchasing cooperatives, and elimination of some mandated benefits are intended to improve the market for those who previously desired to purchase insurance but were unable to do so. However, these reforms will make insurance more expensive for many who previously purchased and so now may not. Moreover, the groups these reforms will hurt somewhat far outnumber the groups they help a lot. Therefore, we can have no confidence that these reforms will advance us further toward the twin goals of universal access and cost containment. At best, they will stabilize the portion of the market they address (usually, small employers groups) from further decay; at worst, they may increase the number of uninsured in a market of voluntary purchase.

Small group market reforms are designed to accomplish two important efficiency objectives. First, they induce insurers to behave more consistently with the fundamental premises of group insurance by minimizing the degree of individual medical underwriting. Rather than imposing laborious regulatory oversight of discrete underwriting techniques such as blacklisting, cherry picking, and churning, the private reinsurance mechanism achieves this goal through an incentive-based system. The reinsurance mechanism encourages the industry to assume all risks at the same time that it assesses the industry for the costs of higher risks passed on to the reinsurance pool. Second, these reforms help to reorient the industry from competition based on risk selection to competition based on risk management.

Health insurers can best contribute to social welfare, first, by insuring as broadly as possible, and second by actively managing the risks they insure. Management takes the form of policing the costs of care through provider controls imposed collectively on behalf of their subscribers. At the same time, some price variability is desirable since individual subscribers do control their health risks and attendant costs of treatment to some degree. Therefore, some degree of risk rating facilitates the use of competitive pressures to manage health care costs. Some degree of risk segmentation may also be necessary for purely logistical or pragmatic reasons in order to allow the functioning of a competitive market that gives consumers a range of choices among insurance options. Small group market reforms attempt to strike a balance among these competing objectives by guaranteeing open enrollment and continuity of coverage, allowing limited price variation, but minimizing risk selection in favor of competition based on efficiency in the delivery of medical care.

Despite these considerable advantages, small group market reforms, as presently structured, will not achieve the fundamental goals of health care reform to the extent the industry would hope. In the insurance industry's own words, these reforms are aimed only at "availability, not affordability," meaning they are only designed to offer insurance to any willing purchaser at prices that do not far exceed the market average, not to impose rate regulation or reduce prices across the market. Insurers hope that focusing competitive pressures on the efficiency of medical care delivery will eventually lower prices, but in the short term the reforms will have just the opposite effect. These reforms will raise prices because they make insurance most attractive to the highest risk groups by holding prices to less than the policy's actuarial value. The excess is assessed against the premiums paid by all small group purchasers, which will inevitably drive an undetermined number of low risk purchasers out of the market, thus raising the market average even more.

Moreover, insurance can be said to be accessible to high risk groups only to the extent that its price does not vary dramatically from the average. However, the rating bands

advocated by the industry allow too much variability to make insurance affordable to small groups of older or unhealthy workers. It is a relatively simple matter to make the rating restrictions more severe, as several states have done and as some federal bills have proposed, by moving closer toward community rating. But community rating is difficult to administer in a voluntary market for the reasons discussed below.

Even if some workable compromise can be found for the rate compression problem, these reforms as presently constructed will not enhance access to the extent the industry would hope; indeed, they have the potential to decrease the prevalence of private insurance. Some highly publicized cases of insurance denial for small employers may involve customers desperate to purchase at any reasonable price, but this does not appear to characterize the bulk of the working uninsured.

Several surveys have demonstrated that only a minority, and perhaps a very small minority, of people lack insurance because they have an uninsurable condition or can obtain only substandard coverage. The Congressional Office of Technology Assessment questioned 73 commercial insurers in 1988 and found that about three-quarters of all individual and small group applicants are offered coverage at standard rates. Of the remaining applicants, 15 to 20 percent are offered substandard coverage which usually means a permanent exclusion of preexisting conditions, but sometimes means standard coverage at rates 50 percent or more higher than the norm for a given age group. Commercial insurers deny only 8 percent of individual applicants.¹ Because applicants who are likely to be turned down usually apply to more than one company, these figures represent an upper bound of the number of uninsurable individuals. A lower bound estimate comes from the 1987 National Medical Expenditure Survey, which questioned individuals, not insurers. According to that data, only 2.5 percent of those without insurance have been denied standard coverage at standard rates.² This is a level of uninsurable applicants that could easily be absorbed by the high-risk pools that already exist in 26 states or by the Blue Cross plans that maintain open enrollment and community rating in 14 states.

For the most part, workers lack insurance because it is too expensive even at average rates. Some employers may be unwilling to purchase insurance even at prices far below market averages. HIAA provides some insight into insurance purchasing proclivities via a questionnaire it administered to a nationally representative stratified sampling of over 3000 employers. Its 1990 employer survey revealed that labor market factors and underlying costs, not product availability, account for a large portion of firms not offering health insurance.³ Firms without health insurance have nearly three times as many employees earning less than \$10,000 as do firms with insurance (33 percent compared to 12 percent). Employers also tend not to offer insurance for jobs with high employee turnover. The turnover rate for uninsured firms is three times the rate for insured firms (39 percent versus 13 percent). When asked their reasons for not purchasing insurance, only 30 percent of these firms cited unavailability of an acceptable plan as very important, while three quarters cited expense and over half cited low profits as very important reasons for not offering insurance. Similar findings are reflected in surveys conducted by the federal government, the National Federation of Independent Business, Robert Wood Johnson Foundation grantees, and Catherine McLaughlin and her associates.⁴

One way to lower these financial barriers is to strip away enough benefits to make insurance affordable. Based on research showing that state mandated benefit laws add 10-to-20 percent to the cost of insurance,⁵ 31 states have enacted so-called "bare bones" law that allow insurers to sell stripped down coverage to previously uninsured purchasers at greatly reduced prices. However, in most states these efforts have been a dismal failure, and have produced only a modest response in the best circumstances. The mandated benefits most subject to criticism -- such as for acupuncture and chiropractic services -- add very little to the cost of insurance,⁶ and the 10 percent savings produced by paring back most mandates⁷ is not sufficient to attract a large number of new subscribers. This range of savings is negated by only a single year of typical inflation. Therefore, insurers have had to reduce prices by drastically limiting the scope of coverage through very high deductibles and copayments or very low overall payment limits. Some bare bones policies cover only 20 days of hospitalization or cap benefits at \$50,000 annually others impose deductibles as of \$1000 or more. This produces an insurance package that is so unattractive few people wish to purchase it despite its reasonable price. Most bare bones states have sold no more than a few hundred policies, and in several states only a few dozen or fewer people have purchased

these plans. However, in some states that offer a standard package of benefits (Missouri, Oklahoma, Oregon and Washington), the results have been more encouraging, although still modest, with policies covering several thousand subscribers.⁸

The second solution to the affordability problem is to call for various forms of subsidy that will encourage the purchase of adequate insurance coverage. However, other real-world tests provide even more discouraging results that suggest that price lowering effects would have to be extraordinarily large in order to work well in a voluntary market. A series of demonstration projects sponsored by the Robert Wood Johnson Foundation over the past three years has shown uninsured small employers to have a frustrating degree of resistance to buying even highly-subsidized health insurance. Most of the demonstration sites achieved far less than 10 percent penetration of their target markets of previously uninsured small groups despite subsidies of one quarter to one half of market value and despite aggressive marketing efforts and purchasing cooperatives in some of the sites.⁹ One third of surveyed employers without insurance in Denver and one fourth in Alabama said they would not contribute *any* amount toward their employees' health insurance.¹⁰ Similar results were experienced in two pilot projects in New York, where an evaluation found that, "at most, the proportion of [small, previously uninsured] firms offering insurance increased 3.5 percentage points" despite a 50 percent subsidy. Moreover, based on survey information, the evaluators concluded that "nearly 60 percent of small firm owners still would not purchase insurance even with a 75 percent price subsidy."¹¹

The problems caused by the apparent insensitivity of uninsured employers to reductions in price are compounded by the high degree of price sensitivity among those who are presently insured. Price sensitivity among presently-insured small employers is a matter for considerable concern because the inevitable effect of the small group reforms is to raise average prices by drawing higher risks into the market. Actuarial simulations of the effect of various rating bands, performed for HIAA and Blue Cross based on data from existing insured groups, estimate an average increase in per capita claims ranging from 5 to 25 percent in the first year.¹² The Society of Actuaries projects that guaranteed issue will result in claims costs increasing from the base year by about 20 percent in first year, 50 percent in second year, 25 percent in third year, and 13 percent in fourth year.¹³

Even if rate compression were not to attract higher risks, however, average market prices might still go up simply as the result of losing some existing good risks. The purpose of the rating bands is to compress the differential between existing low and high risk groups. This necessarily makes insurance more expensive than before for the lowest risks. Therefore, at the margin, some number of previously insured employers can be expected to drop coverage. Subscribers are not priced out of the market only at the high end of the price range. As Mark Pauly has observed, the willingness to pay for insurance varies with one's expected loss. Therefore, marginal price effects can be felt across the full range of risks.¹⁴

How many lower-risk subscribers will drop coverage due to price increases depends on the price sensitivity among existing insured employers. Different attempts to measure price elasticity using dissimilar methodologies have produced widely varying results.¹⁵ However, most economists conclude that employers are fairly to highly price sensitive.¹⁶ Using a conservative elasticity estimate of -2, a 10 percent increase in the price of insurance is likely to result in 20 percent of presently-insured employers dropping coverage.

Of course, disenrolling low-risk groups may be offset by an even greater number of newly enrolling high-risk groups, but this is unlikely. First, projections show that the number of "losers" under various rating bands will far outnumber the number of "winners," since many average risks must suffer a modest increase in order to lower the price for a few very bad risks. For instance, under the rating bands that were being considered in several bills during the 102d Congress, various projections predicted four times as many subscribers would suffer price increases as would receive price reductions.¹⁷ Moreover, even if winners and losers were better balanced, the marginal price effects may be markedly different for currently insured versus currently uninsured employers, such that the former are more likely to drop coverage than the latter are to add it, for a given level of price differential. Therefore, the HIAA estimate that the tighter rating bands being proposed may decrease the level of insurance purchase by 2-to-5 percent is probably realistic.¹⁸

The most dire projections have not been borne out, however, in the states that first implemented small group reforms. No dramatic price increases are reported in Connecticut, North Carolina or Vermont, nor has there been a huge outcry from small employers. Data is

insufficient to determine whether the level of insurance has gone up or down, but an eyeball assessment suggests modest progress. In Connecticut, over 5000 plans have been sold to previously uninsured small employers during two years under market reform.¹⁹ In North Carolina, another early state with a full set of reforms, 7300 new plans were issued in the first year of market reform with 60 percent going to previously uninsured groups.²⁰ And, in California, where small group reforms took effect in mid-1993, insurance regulators are reporting a strong surge of applications for new coverage.²¹

In sum, the working uninsured are composed primarily of two groups: high risks who cannot afford insurance and low risks who cannot afford insurance. Small group reforms will help only the former and will hinder the latter. It is impossible to predict how these counteracting effects at the margin will net out over time, but it is quite possible (although it has not yet happened) that some form of an adverse selection spiral will occur that results in significantly fewer employers voluntarily purchasing insurance than before, although those purchasing will be sicker and thus more needy groups. Even if a price spiral does not result, it is certain that prices will not drop on their own sufficiently to induce most small employers to purchase voluntarily. Therefore, the only effective means to produce universal coverage of workers by private insurance is to mandate the purchase of insurance by all employers or individuals.

Community Rating in a Voluntary Market

In a market of voluntary purchase, community rating has severe feasibility problems because it encourages younger, healthier groups and individuals to avoid purchasing insurance or to self-insure. Refusing to allow insurers to price these better risks accurately drives them from the risk pool, leaving only higher-than-average risks to support the pool. Then, when the pool's average community rate increases even further, still more members dropout, setting up a classic adverse selection spiral that eventually (or quickly) could destroy the market entirely if not corrected.

As a result of these and other concerns, the states that have adopted pure community rating so far have experienced trouble with some commercial insurers withdrawing from the market or failing to offer affordable products to the market, particularly when community rating is applied to the market for individual insurance. In New York, for instance, commercial insurers offer no reasonably-priced standard-coverage policies in the individual market, and in many locations the only real choice for individual subscribers are among HMOs.²² In New Jersey, Blue Cross is the only insurer offering a range of reasonably-priced options to the community-rated individual market.²³ However, both states have an ample supply of companies competing for the small group market, as does Vermont, which also employs community rating.

Skeptics of adverse selection sometimes object that there is no hard or even anecdotal evidence that adverse selection would be a serious problem for health insurance, at least to the extent of destroying the market. They reason that health insurance, unlike life or disability income insurance which are discretionary, is too essential an item to be subject to intensive selection bias.

However, adverse selection problems created by community rating are real. Adverse selection originally forced Blue Cross to abandon community rating in favor of experience rating for groups, and it is presently destroying the market for individual and small group insurance as subscribers select against the Blue Cross community-rated pools. Adverse selection has made it extremely difficult for a significant market in private long-term health care insurance to come into existence, since younger people with little need decline to purchase, and the premiums are too high for older subscribers to afford.²⁴

The pronounced effect of adverse selection on ordinary health insurance is borne out by the experience under the federal law (known as COBRA) that allows employees to pay for continued group coverage for 18 months after leaving a job. Employers and insurers report that COBRA continuation coverage produces claims that are one-third to twice as high as for other group enrollees.²⁵ This is consistent with reports by insurers in the individual and small-group market that premiums for medically underwritten coverage, which screens for adverse selection, are 80-100% less than for guaranteed issue plans.²⁶

Adverse selection has also been a significant problem within larger groups that offer a choice among multiple health plans, each of which carries the same group-community price. Because presently sick patients place more value on their established physician relationships

and on their freedom to select their own specialists, they are more inclined than healthier and younger patients to select traditional, indemnity fee-for-service plans than HMOs. Sick patients also tend to select more generous benefits, and those with dental or mental health problems select insurance that covers those conditions.

These selection biases have been an ongoing, serious problem within the Federal Employees Health Benefits program, which is the largest existing multi-option network. Adverse selection resulted in the high-option (low deductible) fee-for-service plan in one area attracting risks that were 50 percent higher than the plan's actuarial value based on standard risks, whereas the low-option (high deductible) version of the same plan attracted risks that were about 40 percent lower than the plan's value based on standard risks.²⁷ Another study found that a different insurer that offered two plans with the same actuarial value attracted subscribers with 79 percent higher claims to one than to the other.²⁸ As a consequence of these adverse selection problems, several fee-for-service plans and dozens of HMOs withdrew from FEHB during the late 1980s. Similar problems have plagued the California Public Employees Retirement System²⁹ as well as large private employers offering multiple options. In one study, a high-option plan attracted enrollees that were as much as four times more expensive than those who chose the low-option plan from the same employer.³⁰

At present, the most successful attempt at community rating in a voluntary market exists in Rochester, New York, where community rating prevails for about 85 percent of subscribers.³¹ There are several unique aspects of the Rochester market, however. First, Blue Cross dominates the market with 70 percent of the business, and it offers insurance only on a community-rated basis. The Blue Cross plan there has an unusual history, having been started by the business community, which itself is dominated by a few larger employers, the largest of which is Eastman Kodak. This market configuration allows for a much higher level of community cooperation and voluntary health planning than has proven possible in most other locations.³² Blue Cross has negotiated aggressively for provider discounts, which keeps smaller insurance competitors from offering more favorable experience-based rates. Even then, erosion of community rating is setting in as some employers are beginning to self insure or to demand experience-rated premiums.

As revealing as these examples are, they still illustrate selection against community-rated plans only when another form of insurance was available. There are no existing examples of adverse selection when the entire market is community-rated, which would require those opting out to go entirely without insurance. Nevertheless, we know from recent market experience that many average-to-good risk individuals and employers are presently inclined to opt out for reasons relating largely to the price of insurance, not purely due to their own poverty, in a market that is experience or risk-rated. This tendency can only be aggravated by community rating, which will produce dramatic price increases for the youngest (and therefore lower paid) groups and individuals.

In New York state, for instance, community rating prompted a 170 percent price increase by one large insurer for 30 year old males, and a 30 percent increase even for 45 year old males.³³ For group insurance, projections by Blue Cross, Aetna, and the American Academy of Actuaries based on existing business indicate that about 10 percent of small groups (under 25) would experience price increases under community rating of 40 percent or more and about 20 percent of groups would have increases of 20 percent or more.³⁴ These lower-risk subscribers would naturally tend to drop out, while higher-risk subscribers would be drawn into the market, thereby increasing the community rate from its initial position and so drive away even more low-to-average risks. The net result, according to projections made by the Council for Affordable Health Insurance, is that pure community rating for individuals and small employers (under 25) would result in a 25 % increase in the average market premium and a 22 percent reduction in the total number of people insured.³⁵

Much of this effect can be mitigated by allowing community rating by age class, which produces increases of more than 20 and 40 percent for only 4 and 2 percent respectively of the existing individual and small-group market.³⁶ To allow community rating by age differs little from allowing rating bands centered on age groups. Therefore, this fallback position concedes the basic argument that some variation in rates according to individual risk is desirable in a market of voluntary purchase. Whether risk is measured by age or by health status is largely a matter of detail.

Voluntary Purchasing Cooperatives.

One reason the level of uninsurance is so much higher among small employers is the much higher overhead costs that small group purchasers face. Overhead costs are the portion of the premium that is not paid out in direct claims. There are three reasons why this portion is several times higher for smaller groups. First, the per-enrollee cost of marketing a policy to smaller groups are much higher simply because this one-time cost is spread over fewer people. These costs are compounded by the administrative expenses incurred in having to medically underwrite small groups in order to counteract adverse selection. Second, smaller groups have less bargaining clout than large groups, so there is some possibility that insurers are able to exact a higher profit margin (although profit margins for all components of health insurance are quite low). Third, the pure risk premium for small groups must be higher simply because the risk pool is smaller; therefore, the risk reduction created by the Law of Large Numbers is not nearly as great.

As a partial solution to many of these diseconomies of scale, several states and a number of academics have proposed creating purchasing cooperatives for the small group and individual markets. California, Florida, Minnesota, North Carolina, Ohio, Texas, and Washington are leading examples of states that have already taken this step. Voluntary purchasing cooperatives in another form have existed for a number of years under the name of Multiple Employer Welfare Arrangements (MEWAs). These MEWAs have garnered a tarnished reputation due to the mismanagement, bankruptcy and outright fraud that occurred in a number of them. However, the current proposals for small group purchasing cooperatives differ in several crucial respects. MEWAs are usually themselves insurers, not merely marketing services for other insurers. Their mismanagement occurred because many escaped regulation due to confusion over the applicability of ERISA's preemption of state regulation of self insurance.³⁷ More successful examples of purchasing cooperatives have operated in several demonstration cites sponsored by the Robert Wood Johnson Foundation.

Purchasing cooperatives create several decided advantages for both small employers and insurers. First, the search costs relative to the product costs in shopping for insurance are considerable for small employers, as are the marketing costs for insurers. Small employers do not have the size or money to justify hiring benefits managers to perform this task for them. Studies and demonstrations reveal that insurers have to exert much greater effort to attract small employers' attention since they are often too busy running the business to attend to the complexities of selecting health insurance. Purchasing cooperatives help to create for the small group market the same expertise and economies of scale that exist in the benefits departments of larger employers.

Second, purchasing cooperatives offer individual employees within small groups the same (or an even better) menu of choice as is typically given to employees of large firms. Small employers that do offer insurance usually select only a single option and usually one that is not managed care (HMO or PPO). Purchasing cooperatives provide employees access to a much broader range of the market by presenting them a full range of insurance options.

Third, a properly motivated purchasing cooperative can wield considerably greater market clout, to the bargaining advantage of its members. Finally, depending on the rate mechanism a purchasing cooperative chooses, it can have the effect of creating a much larger risk pool, equivalent to that of a larger employer's, which creates an even greater compression of rates than do the rating bands discussed above, depending on how closely the rating method approaches community rating. Most purchasing cooperative proposals call for strict community rating, although others allow age-adjusted rating, or the full breadth of rating bands proposed by the industry.

The working model of a purchasing cooperative that is most frequently cited is the Council of Smaller Employers (COSE, pronounced "cozy"), which has operated successfully in Cleveland for two decades under the sponsorship of a local business association. COSE, which covers almost 150,000 people, has limited premium increases over a five-year period to about one-third of the trend for other small business in the area, and its administrative expenses are less than 12 percent of premiums, as compared with an average of 27 percent for the small group market. COSE offers 12 health plans, 10 of which are provided by Blue Cross.³⁸ Initial reports are also very encouraging from California's state-sponsored purchasing cooperative for small employers, established in mid 1993. The California cooperative is receiving a strong surge of applications, and it was able to negotiate adjusted

community rates six to 23 percent less than the highly competitive rates available from the California Public Employees Retirement System (CalPERS).³⁹

Other examples of purchasing cooperatives with successful track records come from the public sector. The Federal Employees Health Benefits (FEHB) program has reached a ten-year average increase in costs per enrollee of 9 percent a year despite an aging workforce,⁴⁰ a figure that compares favorably with the double-digit increases that have prevailed in the private sector over the past few years. Even more promising, CalPERS held premium increases to 1.4% in 1993 and to 6.1% the year before, and it is presently demanding a 5% rate rollback.⁴¹

Some commercial insurers, particularly smaller ones, are concerned about the effect that cooperatives are likely to have of narrowing the market for small groups by selecting only a limited number of plans for inclusion. Insurers are also concerned that, in being required to deal with employees on an individual rather than a group basis, they will suffer from biased selection. Changing to a system in which small employers offer a range of insurers rather than each selecting a single plan will fundamentally change the dynamic and perhaps the makeup of the small group market. Employers who choose only a single plan are more likely to select traditional indemnity than a managed care alternative whereas with purchasing cooperatives, employees may opt for managed care products that typically are offered only by larger insurers. Also, offering individual employees multiple choice will greatly increase the amount of plan-switching that occurs during each open enrollment. The ability of individuals to switch rather than requiring the entire group to select new insurance means that insurers are more likely than before to lose business on account of minor differences in costs or benefits.

However, these problems of selection among different insurers and the possibility of exclusion from the market are not fundamentally different than the manner in which insurers deal with very large employers at present. Some of these concerns are problems only for the numerous small insurers who have achieved a market niche by offering only a single type of coverage; for consumers, these concerns represent an improvement in the market. Other concerns are legitimate, but the use of risk adjustment techniques should make it possible to keep these problems in check.

A greater problem is biased selection between the purchasing cooperative and the rest of the market (as distinct from biased selection among insurers within the cooperative). If all that a purchasing cooperative did were to offer a price advantage due to economies of scale, then both good and bad risk groups would have equal reasons to shop for insurance at a cooperative. However, if cooperatives also adopt different rating rules than the rest of the market, they are certain to attract a disproportionate number of higher risk groups that will be favored by rate compression. Unless the purchasing cooperative's efficiencies are large enough to offset its increased risk profile, the resulting increase in rates will drive healthier groups back into the regular market. This will set off an adverse selection spiral unless the cooperative is allowed to screen out bad risks or establish different risk pools.

For instance, COSE was forced by the natural effects of adverse selection to create a separate pool for high-risk groups applying for membership and to turn down 20 percent of applicants. Thus, it turns out that COSE has been able to maintain its success in holding down costs partly by refusing high-risk groups. For instance, Kaiser calculated that its COSE business was 5 percent less risky than its non-COSE small group business.⁴² State-sponsored cooperatives will not have this advantage.

The initial start-up of the California small-group purchasing cooperative has been more successful despite these concerns because there, the rating method used inside the cooperative pool allows for age-based risk adjustment and so does not differ as dramatically from the rating reforms applied to the rest of the market. Moreover, the California pool has been able to negotiate very advantageous rates that remain attractive to healthy groups despite the greater compression in its rates.

There are two possible remedies for market selection problems created by purchasing cooperatives. One is to apply the same rating reforms both inside and outside of the cooperatives. This places cooperative insurers on more even footing with noncooperative insurers. This compromise produces the felicitous result that noncooperative insurers will be forced to compete with the prices established within the cooperative; in other words, the entire market would feel the effects of the cooperative's economies of scale. It also allows

cooperatives to prove themselves by market performance rather than having to force the entire market into an untested new system.

A second method for reducing selection problems is to make the cooperative the exclusive source for insurance purchase in the small group (or individual) market. That is, small employers, if they wish to purchase insurance, must do so through the cooperative. Naturally, this will escalate insurers' concerns over market exclusion. However, if purchasing cooperatives are not exclusive, then insurers will be allowed to continue the duplicative marketing efforts that contribute to the higher costs that cooperatives are intended to eliminate. Furthermore, nonexclusive purchasing cooperatives already exist in almost every state (in the form of MEWAs) by virtue of natural market forces and voluntary cooperation among employers.⁴³ If cooperatives are not made the exclusive source of insurance, it is not clear that authorizing legislation creates any innovation beyond what the market is already capable of producing on its own operating under the guaranteed issue and rating rules discussed above. The only real effect of nonexclusive purchasing cooperative legislation is to extend those reforms to MEWAs.

Selection problems will manifest themselves in yet another way: at the borders of the regulated market. Restricting the cooperative to small groups creates border-policing problems. For instance, large employers with older or sicker workforces who are already purchasing insurance on their own will have an incentive to break their workforces into artificially smaller groups so that the riskier workers can be sent to the community-rated pool. This can be done simply by redefining corporate subsidiaries in a gerrymandered fashion. Obviously, this creates a selection problem and is unfair to the small group pool since the healthy component of the larger employer market does not contribute to the pool. Therefore, this strategy will have to be monitored.

Notes

1. U.S. Congressional Office of Technology Assessment, Medical Testing and Health Insurance, Aug. 1988.
2. Karen Beauregard, Persons Denied Private Health Insurance Due to Poor Health, (Rockville, MD: Agency for Health Care Policy and Research Pub. No. 92-0016, Dec. 1991).
3. C. Lippert, E. Wicks, Critical distinctions: how firms that offer health benefits differ from those that do not. Washington, D.C.: HIAA, 1991 (based on HIAA 1990 employer survey).
4. Stephen H. Long and M. Susan Marquis, "Gaps in Employer Coverage: Lack of Supply or Lack of Demand?" *Health Affairs*, vol. 12 (Supp. 1993), pp. 282-293; Charles P. Hall and John M. Kuder, "Small Business and Health Care — Results of a Survey," The National Federation of Independent Business (NFIB) Foundation, 1990; Catherine G. McLaughlin and Wendy K. Zellers, "The Shortcomings of Voluntarism in the Small-Group Insurance Market," *Health Affairs*, vol. 11, no. 2 (summer 1992), pp. 28-40; Catherine G. McLaughlin, "The Dilemma of Affordability—Health Insurance for Small Businesses," in Robert B. Helms, ed. *American Health Policy: Critical Issues for Reform* (Washington, D.C.: American Enterprise Institute, 1993), pp. 152-66; W. David Helms, Anne K. Gauthier, and Daniel M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs*, vol. 11, no. 2 (summer 1992), pp. 7-27.
5. Gail A. Jensen, "Regulating the Content of Health Plans," in Robert B. Helms, ed. *American Health Policy: Critical Issues for Reform* (Washington, D.C.: American Enterprise Institute, 1993), pp. 167-93.
6. U.S. Government Accounting Office, "Access to Health Insurance: State Efforts to Assist Small Businesses," GAO/HRD 92-90 (May 1992), p. 32.
7. It is not possible to eliminate all mandates since some — such as guaranteed renewability and continuity of coverage laws and requiring family policies to cover newborns despite their preexisting congenital defects — are highly desirable and promote the goal of increased coverage.
8. See Generally, Families USA, "No Sale: The Failure of Barebones Insurance," July 1993; Susan Laudicina, "Impact of State Basic Benefit Laws on the Uninsured," (Washington, D.C.: Blue Cross and Blue Shield Association, Dec. 1992); Patricia A. Butler, "Flesh or Bones? Early Experience of State Limited Benefit Health Insurance Laws," (Portland MN: National Academy for State Health Policy, Aug. 1992).
9. W. David Helms, Anne K. Gauthier, and Daniel M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs*, vol. 11, no. 2 (summer 1992), pp. 7-27.

10. U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health. Private health insurance: options for reform. Washington, D.C.: U.S. Govt. Printing Office, Sept. 20, 1990 (Comm. Print 101-35) (referencing remarks of Judith Glazner (Colorado) and Hugh Davis (Alabama) at a seminar entitled "Health Insurance for the Uninsured: Strategies and Policy Options for a Public/Private Partnership," Washington, D.C., May 31, 1990). However, another opinion survey found that a price reduction of 50 percent would induce half of small firms now without insurance to purchase. Jennifer N. Edwards, Robert J. Blendon, Robert Leitman, Ellen Morrison, Ian Morrison, and Humphrey Taylor, "Small Business and the National Health Care Reform Debate," *Health Affairs*, vol. 11, no. 1 (Spring 1992), pp. 164-173.
11. However, these findings were likely biased by severe restrictions in eligibility for the program. For instance, the firm owners were precluded from participating and from requiring employees to pay any portion of the premium. K. Thorpe, A. Hendricks, D. Garnick, K. Donelan, and J. Newhouse, "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance," *Journal of the American Medical Association*, vol. 267 (1992), pp. 945-48.
12. P. Anthony Hammond, "H.R. 3626 and its Effects on the Small-Employer Market," Health Insurance Association of America, June 1992.
13. Society of Actuaries, "Variation by Duration in Small Group Medical Insurance Claims," Sept. 5, 1991.
14. Mark Pauly, "Fairness and Feasibility in National Health Care Systems," *Health Economics*, vol. 1 (1992), pp. 93-103.
15. For instance, it is known that workers will switch plans to avoid relatively minor costs, reflecting a high level of price sensitivity. On the other hand, deep discounts in the cost of insurance do not induce many presently-insured employers to add coverage. This perceived difference, if it is real, may reflect one of the following phenomena: (1) workers are more price sensitive than employers; (2) insured workforces are more price sensitive than uninsured ones; (3) price sensitivity varies widely and these two observations come from opposite ends of the spectrum.
16. See Michael A. Morrissey, *Price Sensitivity in Health Care: Implications for Health Care Policy* (Washington, D.C.: The NFIB Foundation, 1992), pp. 37-53.
17. Mark A. Hall, "The Political Economics of Health Insurance Market Reform," *Health Affairs*, vol. 11, no. 2 (summer 1992), pp. 108-124.
18. P. Anthony Hammond, H.R. 3626 and its Effects on the Small-Employer Market, Health Insurance Association of America, June 1992.
19. Connecticut Small Employer Health Reinsurance Pool, "Market Place Report," May 1993. The report gives no data about the number of employers dropping coverage, so it is not yet possible to determine the effect on overall level of coverage.
20. Personal communication with Allen Feezor, Chief Deputy Commissioner of Insurance. However, there is no information on the rate of disenrollment during the same period.
21. BNA Health Care Daily, July 7, 1993.
22. The individual policies offered by the only two commercial insurers participating either are extremely expensive (50-100 percent more than other plans) or have very high deductibles (\$2500-\$5000). Blue Cross offers reasonably-priced fee-for-service options to individuals in some but not all parts of the state.
23. BNA Health Care Daily, Aug. 5, 1993.
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26. Testimony presented to the NAIC Health Care Insurance Access Working Group, Sept. 16, 1991, in Pittsburgh PA; U.S. Government Accounting Office, Access to Health Insurance: State Efforts to Assist Small Businesses, GAO/HRD 92-90 (May 1992), p. 24.
27. Although the risk-neutral value of the high-option plan was only 42 percent greater than the low-option plan, the actual costs (measured by experience-based premiums charged) for subscribers in the high-option plan were 264 percent higher. Institute of Medicine, *Employment and Health Benefits: A Connection at Risk*, Marilyn J. Field and Harold T. Shapiro, eds. (Washington, D.C.: National Academy Press, 1993), p. 176.

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32. Compare the experience described by Larry Brown and Catherine McLaughlin in "Constraining Costs at the Community Level: A Critique," *Health Affairs* (Winter 1990), pp. 5-28.
33. Henry Gilgoff, "Dialing in Desperation: Coming Change in Insurance Law Sparks Panic," *Newsday*, March 12, 1993. However, these increases also reflect underlying increases in the cost of care.
34. American Academy of Actuaries, "An Analysis of Mandated Community Rating," March 1993; William R. Jones, Charles T. Doe, and Jonathan M. Topodas, "Pure Community Rating: A Quick Fix to Avoid," *Journal of American Health Policy*, Jan/Feb. 1993, pp. 29-33 (representing AETNA). See also Kenneth E. Thorpe, "Expanding Employment-Based Health Insurance: Is Small Group Reform the Answer?" *Inquiry*, vol. 29 (Summer 1992), pp. 128-136 (with move to community rating, 35 percent of groups would have price increases of 30 percent or more).
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36. American Academy of Actuaries, note 48.
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39. BNA Health Law Reporter, May 27, 1993, p. 684.
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41. BNA Health Care Policy Report, March 8, 1993, p. 21. See also Roger Feldman and Bryan Dowd, "The Effectiveness of Managed Competition: Results from a Natural Experiment," conference paper presented at, American Enterprise Institute, Health Care Expenditure Controls: Political and Economic Issues, April 21-22, 1993 (reporting results from the program for Minnesota state employees).
42. U.S. Government Accounting Office, Access to Health Insurance: State Efforts to Assist Small Businesses, GAO/HRD 92-90 (May 1992), p. 54; National Health Policy Forum, "Multiple Employer Purchasing Groups (METs, MEWAs, HINs, HIPCs): The Challenge of Meshing ERISA Standards with Health Insurance Reform," Issue Brief No. 604 (Washington, D.C., 1992).
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TESTIMONY OF R. GLENN HUBBARD
PROFESSOR OF ECONOMICS AND FINANCE, COLUMBIA UNIVERSITY
BEFORE THE
HEALTH SUBCOMMITTEE, COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear before you today to discuss economic issues relating to reform of the nation's health care system.

The coming months (or even years) will witness a significant debate over "health care reform." While numerous intellectual foundations for reform have been discussed in academic and public policy circles for at least a decade, the current debate will likely center on the *Health Security Act* (H.R. 3600/S. 1757) unveiled by President Clinton last fall, and competing plans offered by both Republicans and Democrats (including for example the *Managed Competition Act*, "Cooper-Grandy Plan", H.R. 3222/S. 1579; and *Health Equity and Access Reform Today Act*, "HEART," S.1770).

To evaluate these plans, we need to remind ourselves what the central issues are. The problem is not a substandard quality of health care: U.S. physicians treat patients using the most advanced technology and drug therapy available in the world, and the United States is the preeminent center of medical research. In part as a consequence of these advantages, we are enjoying both longer and healthier lives than did our predecessors.

The central problems for discussion are *access* and *cost*. First, more than 35 million Americans are estimated to have no health insurance, requiring them to seek acute care in emergency rooms. Second, the growth in medical costs is unsustainable. Medical expenditures are now more than 12% of GDP, up from about 5% in 1960. At this rate of growth in age-adjusted medical expenditures (adjusting also for changes in the average age of the population), medical costs would account for about one-fourth of GDP by 2030.

More narrowly put, the debate over health care reform is generally one over reforms of the market for *health insurance*. "Access" and "cost" concerns in the health insurance market are not unrelated: Individuals, with some exceptions, are uninsured because the cost of health insurance exceeds the value they place on insurance coverage. There has been a sea change in the role of health insurance in financing medical care in the United States over the past generation. While the majority of medical expenses were paid directly by consumers in 1960, 30 years later, consumers' direct contributions had dropped to 23 percent, with the balance paid by private and public insurance. The incentives offered by insurance -- and government policy toward insurance -- are, in many ways, at the debate's center stage.

I suspect that many (if not most) of us would build on the many successes of the current health insurance system and state our "access" and "cost" concerns as follows. The health insurance system should be privately organized, provide some choice to consumers, be accessible to most citizens at a reasonable cost, and offer broad pooling of health risk based on *social insurance* principles (that is, health status *per se* should not affect an individual's or family's health insurance costs). For a number of reasons relating both to the economics of medical care and the economics of insurance, this outcome is unlikely to prevail in a purely private market. Some form of government intervention will be required. How much intervention is the question that illuminates differences among alternatives.

Expanding Access

A lack of health insurance and a lack of medical care are not the same thing. (Some estimates suggest that the uninsured receive about one-half of the medical care they would receive if they were insured.) Why might individuals choose not to purchase health insurance? First, very low-income individuals value an additional dollar of money income very highly for the purchase of a range of necessities, making health insurance unattractive, given the availability of uncompensated care. Second some individuals -- particularly the young -- may believe themselves to be very healthy and/or simply not perceive the risky consequences of their action. Finally, some individuals find insurance too costly, deciding to self-insure because the premiums charged are high relative to those charged to similarly situated individuals.

To ensure that all Americans purchase health insurance requires the imposition of an *individual mandate*, the first intervention I shall mention. Simply put, all individuals and families must purchase at least some basic reference package of benefits. Such a mandate is an integral part of the HEART proposal of Senators Chafee and Dole.

It is important that the mandate be placed at the *individual*, rather than the *employer*, level. This observation stems directly from the simple notion that the total amount of compensation that an employer can pay an employee depends on that employee's productivity. That is, in the long run, the profits of anonymous shareholders will not finance the mandated benefits. As long as employer-mandated benefits do not affect productivity, the employee's wages and other non-

health compensation must fall. The Administration's rather generous mandated benefit would be paid for by a hidden tax on benefit recipients.¹

Placing the mandate on the individual rather than the employer also avoids the problem of potential job losses for individuals whose wages are sufficiently near the minimum wage that they cannot fall to offset the purchase of health insurance. With an individual mandate, it is important to provide a tax credit to very low-income individuals sufficient to purchase a basic plan; the credit could be phased out gradually as income rises.

It is also important that the basic package cover a minimum set of benefits rather than a generous set to avoid over-consumption of medical services and ensure that, at the margin, consumers pay the full cost if they choose to buy extra insurance. How could this be accomplished? Currently, the federal tax subsidy for employer-provided health insurance is open-ended, conferring relatively larger subsidies for the generous plans of higher-income workers. Numerous empirical studies have documented the demand-enhancing aspect of this favorable tax treatment of health insurance.² To remedy this tax bias, the actuarial value of a basic benefits package could continue to be nontaxed for individuals; actuarial values in excess of this level could be considered taxable income. Such an approach does not eliminate individuals' choice, but does require them to face the full cost of very generous plans at the margin. This modification of existing law, while improving incentives, generates revenue to finance the provision of health insurance tax credits.³ (I return to the subject of "financing" below.)

Accepting for illustration broad parameters of President Clinton's proposal, let's assume that individuals will be required to purchase insurance on their own or via their employers through

¹Recent studies by Jonathan Gruber of M.I.T. and Alan Krueger of Princeton University have documented that mandates reduce other compensation roughly one for one.

²Research by Martin Feldstein and by Feldstein and Bernard Friedman in the 1970s are the seminal contributions to the literature on the loss in economic efficiency of failing to tax employer-provided health insurance. Recently, Jonathan Gruber and James Poterba of M.I.T. found that, in response to the partial income tax deduction for health insurance costs to self-employed workers, under the Tax Reform Act of 1986, increased the demand for insurance coverage.

³The Administration's proposal would tax in the distant future (ten years after enactment) employees on health benefits not part of the basic benefits package. The Cooper-Grandy plan would limit employer deductions to the cost of the lowest-price "accountable health plan" in each region. The HEART proposal follows a similar (though less binding) limit on deductibility of employer health contributions, but employer-paid health insurance premiums in excess of the "tax cap" will be taxable to the employee.

health alliances that bargain with insurers.⁴ To ensure that consumers face appropriate incentives in their utilization of medical services, insurance plans should offer managed care options and traditional fee-for-services plans (but with high deductibles and copayments). The Administration proposal's lack of serious cost sharing in its so-called "high cost sharing" plan is lamentable in this respect.

How can reform make sure that individuals' access is not restricted by health status? A sensible approach (the second intervention I shall mention) is that insurers would not be permitted to discriminate based on preexisting conditions.⁵ To avoid losses for plans with sicker than average enrollees and gains for plans with healthier than average enrollees, *health risk adjusters* would be used. (The plans with healthier than average enrollees would pay contributions to a health risk pool, while those with sicker than average enrollees would receive transfers from the pool.) The operation of health risk pools significantly reduces the scope for insurers' "cream skimming" of favorable risks present in the current system.⁶

⁴ The Administration proposal would allow employers with more than 5000 employees to form corporate alliances. Given the experimental nature of alliances and the success of the current system for large employers, a better strategy might be to allow employers with more than 100 workers to purchase insurance on their own or self-insure, as in the Cooper-Grandy and HEART proposals.

⁵ The Administration, Cooper-Grandy, and HEART proposals each offer restrictions in this vein.

⁶ Health risk adjustment schemes are not as rigid as they might appear at first glance. It is possible to vary transfers according to a number of additional variables, including gender, geographic location, industry or occupational categories, or health habits (*e.g.*, smoking). The important underlying premise is that adjustments do not depend on health status.

Two logistical issues complicate implementation of the health risk pooling proposal—design of individual health status adjustment factors and mechanisms for scheduler payments to insurers.

Each year, members of the pool's population would be divided into one of a number of mutually exclusive health status categories. Categorization could be implemented using diagnostic information already collected by health insurance plans on inpatient and outpatient claims. Indeed, applied research by public health specialists, statisticians, and economists has already produced methods for predicting health care costs based on the health characteristics of the covered population. Leading examples include the Ambulatory Care Group system developed at Johns Hopkins University and the Diagnostic Cost Group developed at Boston University. The Department of Health and Human Services could fund technical and implementation research to develop workable health status adjustment systems for use by the states.

Second, payments to and from the risk pool could be prospective or retrospective. Prospective payments would be based on the health status adjustment factor determined before

Two features of a good health risk adjustment system are important. First, risk pool payments should equal the difference between the *expected* average expenditures of the groups and the average of all individuals in the pool.⁷ Since payments reflect average not actual expenditures, insurers face incentives to control costs. (This is different from "community rating," in which all individuals would pay shares of the cost of actual expenditures, with no incentive to control costs.) Second, premiums should vary with age. Since average health care expenses rise with age, individuals should have an incentive to finance those average expenses. If premiums do not vary with age, we further our already significant fiscal intergenerational redistribution from the young to the elderly. The Administration proposal discusses health risk adjustment, but provides few details. The limited discussion suggests that the plan will fail to age-adjust insurance premiums.

Another access question relates to how individuals will be able to maintain insurance coverage if they change jobs. The Clinton proposal (along with most reform proposals in the public debate) would guarantee individuals' access to health insurance if they move or change jobs. Individuals becoming unemployed would be eligible for taxpayer subsidies to purchase insurance.

Controlling Costs

Expanding access to health insurance without addressing underlying causes of spiraling health insurance (and health care) costs is not likely to be a viable strategy for "comprehensive" reform. The crux of the problem is this: The mix of medical care services provided is not

the service period for each enrollee, while retrospective payments would be based on the health status adjustment factor determined during the service period. There are advantages and disadvantages associated with each; the important point is that both payment mechanisms are based on expected, not actual expenditures.

An example illustrating the operation of the health risk pool is instructive. Suppose that an eligible individual in one of the risk pools wants to purchase a reference benefit package at the premium charged. The premium would be paid to the insurer, though the amount ultimately received by the issuing insurer would be subject to a health status adjustment. Each eligible individual in the pool would be assigned to a health status category each year. Health status categories would be assigned a weight based on expected health care costs relative to the average for the covered population in the pool. The insurer in the example would compute an average weight for all individuals in the pool covered under its policies. If that average weight is less than the statewide average, the insurer would be required to make a contribution to the pool; if the insurer had an average weight exceeding the statewide average, it would receive a net transfer from the pool.

⁷ In equilibrium, though premiums would not be regulated, premiums for coverage would be independent of health status.

necessarily that which fully informed consumers would purchase, and such services are not produced at minimum cost. Economists have generally focused attention on problems in insurance markets. This argument incorporates aspects of moral hazard (*i.e.* that insurance for fee-for-service medical care with low cost sharing engenders excess demand for medical services) and the distortion of the perceived price of health insurance (owing to the favorable tax treatment under both the income and payroll taxes.)

This is not to say that relatively efficient forms of health insurance coverage are not possible in the marketplace. Options with "managed care" (in which the health plan purchases a package of health care through, say, a health maintenance organization at a lower cost than fee-for-service medicine) or fee-for-service coverage with deductibles and copayments are available. Three factors in the market for health insurance have probably reduced the demand for such alternative, however. These factors include: the tax subsidies mentioned above; limited consumer information about the quality of services of health-care providers, forcing "price" to be taken as a measure of quality; and opportunities for favorable risk selection by insurers in the marketplace.

Two "cost" issues loom large in the debate over health insurance reform, the cost discussed above of extending access to the currently uninsured and reducing the growth of medical costs. The former can be financed gradually by reducing the current tax subsidy to employer-provided insurance, raising other taxes (as in the "sin tax" increases in the Administration's proposal), and redirecting current federal contributions for uncompensated care (so-called "disproportionate share payments"). The Administration's proposal aims to finance access and achieve control of the second cost issue by trimming the growth in federal contributions to public insurance programs and by what amounts to regulatory price controls; much less restrictive options are presented in the Cooper-Grandy and HEART proposals.

The bulk of the financing of the Administration's plan comes from savings in Medicare and Medicaid programs. Wishing inflation in the costs of these programs were lower is, of course, not the same as suggesting specific micro incentives to accomplish the goal. As an astonishing point of reference, the plan initially assumes that, *by 1996*, the rate of growth of federal Medicare and Medicaid spending will be cut by one-third; put more radically, the rate of growth of Medicare and Medicaid spending above general inflation and population growth will be cut in half. If, in practice, cost inflation falls by much less, providers would have to shift the cost of caring for Medicare and Medicaid patients by increasing charges to private (generally insured) patients.

This pattern is sadly familiar, but with a new twist. As private insurance premiums rise, premium caps in the Administration's proposal would bind. *Macro-level* budgets and caps do not provide *micro* incentives. There is simply no reason to believe that this enforced macro cost containment would be borne by the infamous "waste, fraud, and abuse." Indeed, there is significant reason to believe that this aspect of the proposal would discourage innovation and provider expenditures with long-term payoffs.

Determining Government's Role

I mentioned at the outset that, at least under my interpretation of what most of us seek from reform of health insurance markets, some government intervention will be necessary. Much of the regulation of insurance market reforms can build on existing state-level regulation. Additional federal involvement would come in the form of tax policy changes and the design of basic benefits packages for managed care and fee-for-service options. It is possible to construct a National Benefits Commission to determine benefits packages, though care must be taken to avoid "regulatory capture" by provider groups.

President Clinton's National Health Care Board offers breathtakingly sweeping intervention and government-directed micro-management of the health care industry. In addition to determining the composition of basic benefits packages, the National Health Board would set national health spending targets, establish baseline budgets for health alliances, and decide upon the "reasonableness" of drug prices. The Board would have presidentially appointed members like the Federal Reserve Board. Its independence from the political process would be far less than the Fed's, however, since the term of the National Health Board's chairman would match that of the President; the chairman, moreover, would serve at the President's pleasure. The Board would also be empowered to create a new federal staff.

In addition to the creation of the National Health Board, the Administration's proposal places the Secretary of Health and Human Services in charge of initiatives to set targets for the number of physicians to be trained in primary care and specialties. This heavy-handed intervention ignores the natural increase in the reward to primary care physicians as health insurance becomes more widely available, and fails to use effective monetary incentives for prospective physicians.

President Clinton has succeeded in reinvigorating the national debate over health care reform. His own plan, while containing many good ideas (medical malpractice reform, for example), suffers from its emphasis on regulation and macro controls rather than micro incentives. Indeed, it is hard to escape the conclusion that the proposal is intended to increase government regulation of the health care industry as much as it is to reform health insurance markets. Before the legislative process begins the long march of compromise with competing reform ideas, participants should try to answer two simple questions: What are the goals of the plan? Is a given plan the most efficient way to achieve those goals? As I reached the end of the Administration Working Group's treatise, I at least would not guess the answers for that plan. The HEART and Cooper-Grandy proposals provide better starting points for debate.

Concluding Remarks

I have proposed only a very brief review of economic issues surrounding debate over "access" and "cost containment" aspects of health care reform. Let me close with four observations

regarding the future debate of the President's plan and competing proposals:

1) *There is no free lunch.* In the short run (and possibly in the long run), significantly expanded access to health insurance is likely to be costly. Insuring the currently uninsured is expensive, though the cost would be reduced by scaling back current federal payments for uncompensated care. Moreover, to the extent that the risk pooling proposal with health status adjustments increases the number of individuals with coverage, average premiums paid by those currently covered may well rise.

In the course of the debate over the President's proposal, mandates for health insurance coverage for individuals should be considered very seriously. A mandate for individual coverage - *e.g.*, requiring some basic benefit plan - offers an advantage of broadening the pool of enrollees for sharing risk. However, to be realistic, such a mandate would have to be accompanied by more complete provision of health insurance tax credits to low-income individuals. In addition, to avoid regulation of premiums charged by insurers, funding for such tax credits may have to increase more rapidly in the short run than envisioned in most proposals.

2) *Some regulation cannot be avoided.* Proposals to expand access to health insurance in the small group market at a reasonable cost necessarily involve regulatory intervention. Absent such intervention, favorable risk selection by insurers is unlikely to end. Regulation should seek to promote the basic social insurance principles I discussed earlier, and should not attempt to set premiums.

3) *At some point, the open-ended tax subsidy for employer provided health insurance will have to be examined.* The current subsidy encourages consumption of medical services and is distributionally inequitable, conferring no benefits to low-income workers without insurance and considerable benefits to affluent employees. Addressing this issue will nonetheless be difficult; a tax cap set a value other than zero will involve significant definitional questions.

4) *Information collection and dissemination will be important components of comprehensive reform in the search-intensive health care market.* Attention should be focused on direct dissemination to individuals and on group purchasing arrangements (to communicate information to small employers) as suggested in all of the major proposals.

INTERACT

The Institute for Interactive Management

February 25, 1994

The Honorable Fortney (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1114 Longworth House Office Building
Washington DC 20515

Dear Chairman Stark:

Thank you for the opportunity to submit testimony for your hearing on "Alternative Health Care Plans." I am appreciative of your leadership on the health reform issue and share your commitment to coverage for all Americans and to a restructuring of the delivery system to improve efficiency and control costs.

If an "overhaul" of the current system does occur, there will be an extended discussion about various approaches, from single payer to voluntary, and features of a national plan.

In that respect, I am enclosing a copy of a health care reform plan developed by a consortium under the leadership of the Institute for Interactive Management (INTERACT), of which I am chairman, based on systems analysis principles. The Institute is a management consulting and policy group based in Philadelphia, Pennsylvania. It developed the proposal using interactive techniques in conjunction with a number of health care policy experts, providers and employers.

By way of background, INTERACT's charter was an unusual one: to disregard existing financial and professional interests and design an optimal system from the ground up. This design would provide universal coverage and be based on incentives which would change patient and provider behavior to more efficiently use resources. Thus the proposal is as free from self-interest as any you are likely to encounter.

It incorporates centralized federal revenue collection function up front, with governmental control of total ultimate system expenditures through the issuance of individual vouchers on a capitated basis. But there is no regulation of institutional budgets or provider rates as is proposed in some models. Indeed, system resources are subsequently distributed on a free-market basis.

Uniquely, there is a modified capitation feature, with the voucher capitation payment varying according to the health status of the individual. This removes the incentive for providers to turn down sick individuals, and at the same time allows small provider groups, even individual practitioners, to survive without large-scale pooling, if they so desire.

A key point is that the risk of overuse of the system and overpayment for other providers' services is placed on the primary care provider. He or she becomes the system's resource manager -- a mini-HMO if you will -- backed up to stop-loss insurance. We feel this approach and the other incentives of the plan would lead most practitioners to aggregate in integrated health systems or other organizations.

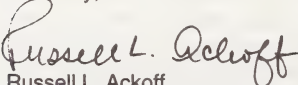
Finally, the design incorporates a wellness component which is separately funded from the basic remedial care program. We feel patient behavioral change is essential to decreasing the demands we place on the health care system and thus to long term cost control. Participation in wellness activities is encouraged through a tax break for the individual.

While we feel the plan as set forth is organic and well-integrated, we also feel that many of the ideas embodied in it, particularly the incentive structure, could be usefully adapted to other plans to strengthen their impact.

Attached is a summary of the INTERACT plan. The plan is currently being drafted by the House legislative counsel and will be furnished to the Ways and Means Committee for inclusion in this hearing report when completed. I sincerely hope that the INTERACT plan will be a useful addition to the debate.

Again, thank you for the opportunity to participate in the "Alternative Health Care Plan" hearing.

Sincerely,

A handwritten signature in dark ink, reading "Russell L. Ackoff". The signature is fluid and cursive, with the first name "Russell" and last name "Ackoff" clearly legible.

Russell L. Ackoff
Chairman of the Board
INTERACT

INTERACT Plan Overview

The INTERACT Healthcare Reform Plan is built around a set of incentives crafted to produce wise use of health care resources. Some of its features are similar to plans already advanced in the healthcare reform debate. Others are original.

- Covered Population:** All legal residents of the United States are covered, including Medicare and Medicaid populations.
- Mandate:** Individual -- individuals receive a comprehensive voucher from the government. (Employers participate through a tax based on hazards of job or site, similar to workmen's compensation.)
- Revenue Collection/Disbursement:** Revenues flow to the national level, and are returned to the system through vouchers to each individual. Different revenue sources are possible, individual tax is suggested.
- Services Covered:** All medically necessary plus preventive care. Dental, optical, auditory, long-term care, basic funeral are desirable, future resources permitting. Final decision on which services are or are not covered is made annually at the community level. No restriction on development of insurance to provide uncovered procedures outside of system.
- Provision of Services/Risk:** Primary care providers in the system accept the voucher amount and agree to provide all necessary medical services covered in the community. The voucher is a type of capitated payment, but is based on an actuarial calculation of the individual's need for services during the coming year: vouchers for those with cancer or diabetes will be worth much more than vouchers for healthy young people (modification for regional cost differences is allowed).
 - Thus, while the primary care provider accepts the risk of paying for all covered medical services, that risk is decreased by the variation in voucher value. Backup stop-loss insurance to protect against financial ruin is required of all primary care providers.
 - The primary care provider is best able to be the system's "prudent purchaser", and under this model, has a strong incentive to do so.
- Provision of Services/Delivery:** The primary care provider contracts or joins with hospitals, laboratories, specialists, rehab facilities, etc. to serve his or her patients. Economic and practical incentives are expected to lead most primary care providers to aggregate into some kind of group practice or integrated health system, in which voucher income is pooled.
- Protection Against Underservicing:** The incentive for primary care providers to underserve is reduced by the required stop-loss insurance. Further:
 - Organized community practice review coupled with an unparalleled data system and practice standards will reduce intentional underservicing.

- Also, a second opinion is available, with the provider paying if the second opinion differs, while the patient pays if the second opinion agrees with the primary care provider.

- Finally, a yearly bonus is paid to the primary care provider if the individual reenrolls with him: i.e. an incentive to keep the patient not only healthy, but satisfied.

•**Patient Choice:** Provider participation in the system is voluntary, and outside services remain available. The patient may choose any primary care provider in the system (regardless of location), subject to patient load limits, and may change by right once a year. If a particular specialist is desired, the patient must enroll with a primary care provider in the same integrated health system or group practice or having a referral agreement with the specialist (affiliation arrangements are made public each year in advance of the date by which patients must select primary care providers). Services outside the system remain available, but the individual is not relieved of his contribution (premium or tax), and must pay for outside services from his or her own pocket.

•**Information System:** A secure national network of local databases administered by community boards undergirds the system, furnishing central authorities with the health status data necessary to calculate the actuarial value of individual vouchers, and to monitor payment patterns for fraud purposes. Through the system, local boards are able to compare practice patterns against standards and assess the need for local remedial or educational programs.

•**Wellness Program:** A unique feature of the plan is that it incorporates a separate wellness program. A wellness voucher is generated, usable only for wellness activities at programs/facilities certified eligible by the community board. Examples: smoking cessation and exercise/cardiovascular fitness programs. The voucher is funded by a separate budget for wellness, to prevent invasion to pay for acute care services (historically a problem for HMO's).

•**Community Focus:** Oversight for the delivery system, and key decisions on covered services, provider certification, attracting providers to underserved areas, etc., are vested in community boards rather than in the federal government. Separately funded, these boards have the general responsibility to promote the health of those receiving their care in the community, ensure quality of services, monitor practice patterns, and administer the local health care database.

Conclusion:

In comparative terms, the INTERACT plan has a central revenue collection and distribution feature, channeling voucher funds from individual patients to primary care providers. It incorporates an inherent self-limiting budget mechanism, producing at least as great a level of savings as single-payer systems. However, it avoids the rate-setting/price-control mechanisms of most single-payer models.

Its large-scale cost controls work in two ways. At the national level, the "budget" matches the aggregate value of all vouchers issued with the aggregate value of revenues from all sources. At the local level, the benefit package is adjusted by the community board to reflect local priorities, within the total amount of money flowing into the community from all vouchers.

The plan thus allows for competition and price movement among providers of various medical services and products, with the primary care provider being the prudent purchaser.

The capitation feature invokes the efficiency and savings of managed care, while the variability of the voucher amount by health status removes any incentive to refuse care to those who are ill or who are thought normally to be "bad risks". The variable value of the voucher, coupled with stop-loss insurance, also permits smaller groups of providers to "pool" than is normally feasible.

The individual mandate and general requirement that primary care providers accept anyone presenting a voucher remove concerns about portability, availability, and pre-existing conditions.

In short, the INTERACT plan features an unusually flexible, community based, approach to cost savings and universal coverage without detailed governmental regulation. Its wellness program is unique among plans currently under discussion. The principles and incentives on which the proposal is built deserve to be seriously considered both in their own right, and as an "idealized" guide to the assessment of other plans.

INTERACT Plan Overview:

WRITTEN STATEMENT OF PAUL HOUGHLAND, JR., EXECUTIVE DIRECTOR,
OPTICIANS ASSOCIATION OF AMERICA ON HEALTH CARE REFORM
LEGISLATIVE PROPOSALS

SUBMITTED TO THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND
MEANS, FEBRUARY 28, 1994

The Opticians Association of America is pleased to have this opportunity to present its views on health care reform legislation to the members of the House Ways and Means Committee.

OAA represents approximately 40,000 dispensing opticians throughout the United States. Our membership consists of both individual and firm members. Individual members may work for another optician, an ophthalmologist, an optometrist, or one of the large chains which dispenses eyewear. Firm members are small businessmen who own their own independent optical firms and compete with medical doctors (ophthalmologists), optometrists, and the chain stores in dispensing eyewear, both spectacles and contact lenses. The principal issues examined in this statement reflect the concerns of the small, independent firm owner, the heart and soul of our association.

Because we represent independent small businesses, we believe that freedom is the paramount issue. Allowing consumers freedom to shop for eye glasses and contact lenses at stores of their choice is a cardinal tenet of the optician's credo and must be recognized in the final health care reform legislative package.

OAA's Board of Directors has adopted three principal objectives with regard to any health care reform plan adopted by Congress. First, any health care plan which includes vision services must recognize opticians as providers AND at the same time contain strong anti-self referral provisions similar to the prohibitions included in HR 345 introduced by Ways and Means Health Subcommittee Chairman Stark and cosponsored by Representative Levin, a member of the Ways and Means Health Subcommittee.

We are very pleased that significant portions of HR 345 were included in the Omnibus Budget Reconciliation Act of 1993, and strongly support the inclusion of strong anti-referral language in health care reform legislation. With respect to vision care we strongly support extending and improving the ban on self-referrals to prohibit both ophthalmologists and optometrists from making referrals to health care providers with which they have a financial relationship.

Maintaining a level playing field within the vision care field requires the passage of strong language banning self-referrals. We encourage every member of this committee to support the extension of the Stark anti-referral language as the best way to assure the preservation of the kind of competition which will lead to the lowest cost for vision care services to consumers.

Second, any alliances, voluntary or mandatory, must recognize opticians as providers. We recognize that the mandatory alliances found in HR 3600, the Health Security Act, the Administration's health care reform proposal do not command much support in the Health Subcommittee, and we accept that fact. In fairness to the interests of our members, however, we must retain a pragmatic approach to this matter. If the alliances, in either voluntary or mandatory form, remain in the legislation being considered by this committee, we insist upon the inclusion of opticians as providers within these alliances.

Finally, we support the preemption of anti-competitive state laws with regard to allied health professionals (opticians). Our objective here is keeping health care costs to the consumer as low as possible. Studies have shown that where competition with regard to spectacles and contact lenses does not exist, prices for these commodities increase, sometimes sharply.

We recognize much merit in HR 1200, the American Health Security Act of 1993, sponsored by the Honorable Jim McDermott of Washington, a member of this subcommittee, and HR 2610, the Mediplan Act of 1993, introduced by the Honorable Fortney Stark, chairman of the Ways and Means Health Subcommittee, particularly the extensive benefits provided in both plans and the universality of coverage.

However, we prefer an approach which would provide generous benefits, including vision care and universal coverage, while preserving the existing structure of private insurance. We believe significant health care reform can be achieved within a system that relies upon private health insurance sold by private companies competing within the free enterprise system. OAA will back health care reform bills that encourage small businesses to stay in business, and our association will strongly oppose plans which, in our judgment, cripple the entrepreneurial spirit.

We are very supportive of the concept of small business pooling of health insurance purchases. OAA members who are firm owners would benefit greatly from plans to enlarge the purchasing pool for health insurance premium purposes.

As a representative of small businesses, the OAA strongly supports paperwork reduction and standardization of forms used by private health care providers and commercial carriers. It is high time that health care providers spend their time delivering health services not filling out complicated, duplicative forms.

While the Opticians Association of America recognizes the motivation of those who would streamline the provision of health services by amending the antitrust laws, it wishes to urge extreme caution in crafting these modifications. Antitrust exemptions designed to help hospitals and clinics in rural areas share expensive equipment must be written in **very precise legislative language**.

Unfortunately, opticians have suffered from anti-competitive practices, sometimes sanctioned by legislation, in many states. For example, opticians are excluded from providing vision care services within health maintenance organizations in some states. Other states prohibit opticians from fitting contact lenses despite evidence cited by a Federal Trade Commission study which found no significant difference in quality between opticians, ophthalmologists, and optometrists in the fitting of contact lenses. Therefore the OAA approaches any modification of existing antitrust law with great trepidation.

Finally, the Opticians Association of America objects to the inclusion of an entire subtitle in HR 3600 which would change the status of independent contractors not only for health care purposes but also for employment tax purposes. Section 7301 would permit the Internal Revenue Service to issue regulations on "employment status." Section 7302 would increase penalties on businesses who fail to issue accurate Form 1099's. Section 7303 would amend Section 530 of the Revenue Act of 1978 concerning safe harbor provisions. The issues raised by the independent contractor subtitle would do serious damage to productive business arrangements which opticians currently have with certain other vision care providers. Many OAA firm members hire optometrists, contact lens technicians, and other providers in which the independent contractor status is the key element of the relationship. Approval of these IRS proposals would have a serious impact on these relationships. Therefore the OAA strongly opposes these provisions.

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